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Belladonna, with Some of Its Therapeusis.

Read before the South Kansas Medical Society at Newton, Kansas, November 15, 1892,

BY

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PROFESSOR OF OPHTHALMOLOGY AND OTOLOGY IN THE KANSAS MEDICAL COLLEGE.

Belladonna, commonly called deadly night shade, is an old but valuable therapeutic agent. The active principles of belladonna are atropine and belladonnine. Belladonnine is supposed to be identical with hyoscyamine, and is a mydriatic when given internally, but not when applied locally.

Belladonna is readily eliminated by the kidneys. The urine of an atropinized animal will dilate the pupil of another animal.

The carnivora are more easily affected by belladonna than the herbivora. The latter eat large quantities of the leaves with impunity. Horses have been known to eat eight pounds of the leaves, and fifteen grains of atropine are required to poison a rabbit.

Belladonna should not be used with the potash or ammonia salts, or with myotics as a rule. Its action is increased by the addition of hyoscyamus, stramonium and the other mydriatics. It produces dryness of the mucous surfaces when the physiological action of the drug is obtained, but when its effect passes off, increased secretion follows. It stimulates the sympathetic ganglia and thus increases the blood pressure by contracting the arterioles. The heart's action is increased in force by stimulation of its ganglia by belladonna, and increased in frequency by its inhibiting control being lessened. Respiration is increased in depth and frequency. A full dose of the drug increases the bodily temperature from one-half to one degree. Owing to the greater activity of the circulation it causes metamorphosis. It produces tinnitus aurium, vertigo and headache. In some it brings on a wild delirium. It causes a red blush of the skin, similar to that of scarlatina, and sometimes desquamation follows this blush; especially is this liable to occur in fair-skinned persons. It produces mydriasis by stimulating the terminal nerve filaments of the sympathetic and paralysis of the motor oculi.

Therapeutics.—In incontinence of urine, especially in children, there is no one agent equal to belladonna. The physiological effect must be obtained, and children tolerate large doses. From eight to twelve years of age, five to twenty drops of the tincture should be given at bed-hour, or three to five drops of the fluid extract. It will only give relief where there is irritability of the bladder or weakness of the sphincter vesicæ. If caused by acidity of the urine, it fails of the effect and the urine should be rendered alkaline.

In a case of a girl, aged twelve years, who came under my observation seven years ago with central perforation of the cornea, due to trachoma, the action of belladonna in enuresis was happily demonstrated. A solution of atropia was used, four grains to the ounce of distilled water, and one or two drops put in the eye every half hour, while in my office, until there was dryness of the fauces. She was given one ounce of a two-grain solution with instructions to put two or three drops in the eye every four to six hours unless excessive dryness of the throat was produced; then to use but one drop, and if the dryness continued, to lengthen the time to six hours. The third day she was taken to her home some miles distant and called at the office once a week for the next three months, using, meanwhile, the atropine

on an average three times a day. It not only relieved the eye, but also the incontinence of urine, from which she had been suffering all of her life. It should be remembered that in the long-continued use of this drug it may bring on conjunctivitis. Here was a case in which a constitutional effect was produced by local applications.

In nocturnal seminal losses, where the erection is feeble and there is no distinct orgasm, one-sixtieth of a grain of atropine, given at bed-hour, will afford relief. In ovarian neuralgia and dysmenorrhœa of a neuralgic character, sciatica and lumbago, relief is given and often a cure effected by the use of belladonna. One-half to one grain of the extract of belladonna should be given once or twice a day, sufficient to maintain a slight physiological effect, in the first two cases and one-sixtieth of a grain of atropine injected into or near the nerve in sciatica and lumbago and a 6x6 or an 8x8 plaster of belladonna should be worn. The patient should be cautioned to remove the plaster in case the throat became very dry and the pupils spread widely, or either. In the low muttering delirium of typhoid fever, with weak pulse and subsultus tendinum, from two to five drops of the fluid extract of belladonna, given every four to six hours, will greatly benefit the patient.

In the so-called idiopathic form of erysipelas some claim that belladonna has a real curative effect.

There is no agent probably that will relieve aphonia, due to fatigue of the vocal chords, more quickly than atropia.

It has no power to prevent scarlet fever, but is probably of value in those cases in which the rash is retarded.

In sick headache, where there is palor of the face and tinnitus aurium, it is indicated.

It is an excellent remedy in asthma when the secretions are profuse.

Acute coryza with copious watery secretions can be controlled by atropine; 1-120 to 1-60 of a grain, or three drops of the fluid extract and one drop every hour or two afterwards, maintaining a slight physiological effect. On myself I use from ten to fifteen drops of a two-grain solution of atropia as follows:

℞

Atropia sulph.....grs. ii
Aquæ dest.....ʒ i

M. Sig.: Ten to fifteen drops sprayed in the nostril two or three times in twenty-four hours.

Dr. Bishop's formula is a good one, which is as follows:

℞

Morphia sulph.....gr. i
Atrop. sulph.....gr. 1-12

M. Ft. Charts No. vii.

Sig.: Apply to mucous membrane of nose when the secretions become profuse.

In my case this prescription does the work, but the morphine gives me the headache, while the atropine alone checks the secretions without causing headache.

In sore throat, when the mucous membrane is turgid and bluish, with excessive secretions, and in diphtheria, when the exudation is just beginning to form, belladonna is indicated.

One-sixtieth of a grain of atropia, hypodermically at bed-hour, is a valuable agent for the relief of night sweats of phthisis, and the emplastrum belladonna relieves the chest pains.

Excessive sweating may be relieved by the use of atropia, either applied externally or taken internally.

It arrests the secretion of milk and is indicated in cases of excessive lactation.

It is a useful agent in many cases of skin affections.

In ptyalism it is an agent excelled by none. Pyrosis and irritable dyspepsia are relieved by belladonna. It is contra-indicated in cases where the mucous membrane is dry, the arterial system tense or where the delirium is wild and furious (ferox). It is indicated where the mucous secretions are profuse, the arterial tension weak and the delirium low and muttering.

Some of its greatest victories are won in the field of ophthalmology.

Inflammations of the iris or ciliary muscle (iritis or cyclitis) are cut short with atropia. It squeezes the blood out of the iris by di-

lating the pupil, puts the ciliary muscle at rest, and thus cuts short the inflammatory process.

Ulceration of the cornea and phlyctenular keratitis are often relieved by atropine alone, by its soothing effect upon the exposed terminal nerve filaments. In the great majority of inflammations of the eye, whether idiopathic (so-called) or traumatic, atropine is one of the agents used and often the only one. Its action appears to be expended upon the terminal nerve filaments, stimulating the sympathetic and paralyzing the motor oculi. In perforation of the cornea or where it is threatened, if central or some distance from its margin, atropine dilates the pupil and keeps the iris back from the opening, preventing hernia. In case of recent prolapse of the iris it can sometimes be drawn back by the free use of atropine. It is contra-indicated where the perforation is marginal and its physiological antagonist, eserine should be used to draw the margin of the iris away from the opening.

It is used to paralyze the muscle of accommodation in errors of refraction, where the examination is not satisfactory without it and in spasm of the ciliary muscle, thus preventing accommodation and in some cases of eyestrain, effecting a cure by putting the eye at rest.

A case of cataract should not be diagnosed positively without the use of a mydriatic, and when the eye is fully under its influence the merest tyro can ordinarily correctly diagnose the case, and without taking this precaution an adept is liable to be deceived.

There is some danger in using atropine in the eyes of aged persons, as it favors or precipitates glaucoma if there is a tendency in that direction, although the danger is probably exaggerated.

Potter says atropine increases the ocular pressure. Bartholow says it lessens the intraocular pressure.

Noyes' work on the eye for 1890, page 214, reads as follows: "Cocaine, aside from its anæsthetic effect, reduces the tension of the globe in most instances." Again: "Its effects are exerted on both the sensory and sympathetic nerve fibers, and hence its constricting influence on the vessels and reduction of intraocular tension." Page 219, same authority: "It was erroneously thought by Graefe that atropine relieved intraocular tension; when it fully paralyzes the ciliary muscle and iris, the eye often feels much relief. On the contrary, all mydriatics, including muriate of cocoaine, intensifies intraocular pressure simply because the iris is pushed toward the angle of the anterior chamber, while the myotics diminish the pressure because the iris is pulled away from the angle."

In answer to my letter of inquiry respecting these seeming contradictions in his late work, Dr. Noyes says in perfectly normal eyes atropine relieves tension, but where the eyes have a tendency to pathological conditions, like in glaucoma, it increases the tension.

There is an antagonism between opium and belladonna within certain limits. It is one of the most effective agents in opium narcosis, due to its stimulating influence upon the respiratory centers.

Chronic Tubular Nephritis or Chronic Bright's Disease.

By R. E. McVEY, M.D., Topeka, Kansas,

PROFESSOR OF CLINICAL MEDICINE IN THE KANSAS MEDICAL COLLEGE.

Miss A., twenty-four years of age, Swede, has been in this country three years, two years ago had chills and a year ago chills returned, which were followed by what the physician in charge called tonsilitis.

This tonsilitis continued for six weeks, and she said her tonsils had to be lanced five times during that period.

During the tonsilitis the urine was scant and high-colored, and of a brownish color, with more or less distress and desire to relieve the bladder frequently.

Since the tonsilitis she says she has never been well, and has been unable to do any work. Her back has been weak with more or less pain and distress in the lower ex-

tremities. The appetite has been fairly good, but sleep disturbed.

Present condition: The urine is still scant and high-colored, and contains albumen. The albumen is constant and there is œdema of the lower extremities after exertion. Under the microscope the urine presents hyaline casts with epithelial cells attached with red and white blood corpuscles. There is tenderness in both kidneys, with hypertrophy of the left ventricle of the heart. Morning temperature normal, pulse 80. Evening temperature 99½ to 100, pulse 100. Rest more or less disturbed.

The kidneys are the chief servants of the tissues of the body, and through this service they are liable to be affected by the presence in the blood of chemico-toxic and organic infectious substances.

From the history of this case this disease had its origin in an aseptic condition of the blood during the tonsilitis. The reason we think so is because of the changed condition of the urine that is referred to in the history of the case.

What is the significance of the presence of albumen in the urine? The presence of albumen is significant of an abnormal condition of the glomeruli of the kidneys. The function of the glomeruli is to act as filters. Now, if the filters become too porous, or, in other words, too open, substances pass through which should not; hence the transudation of the albumen into the urine.

These changes in the character of the urine, in reference to quality and quantity, are what first direct our attention to disease of the kidneys. An albuminous urine is almost always a concentrated urine and this almost always produces more or less irritation of the urinal tract.

But what is more important than albumen in the urine is casts. The hyaline casts are the ones most frequently found and are the most important form of casts. The structure of the hyaline cast is some coagulated material, probably albumen. They are to a certain extent the ground work for the attachment of the different substances seen under the microscope. The hyaline casts are clear as glass and colorless, and are therefore often difficult to see under the microscope. These casts often contain granular matter, and red and white blood corpuscles and fat cells.

Casts are always significant of alteration in the tubules of the kidneys. Normal urine has no casts.

The width of the cast represents the extent of dilation of the tube through which it comes. Blood corpuscles point to hemorrhage of the kidneys. The capillaries are ruptured and there is an escape of red blood corpuscles into the tubules of the cortex. Epithelium casts point to desquamation of the epithelium in the tubules. White blood corpuscles point to migration of the white cells through the vessels. The fatty granular cells point to fatty degeneration of the kidneys.

Usually Bright's disease is a disease of middle life, but it often makes its appearance in the young through the presence in the blood of organized infectious material being eliminated through the kidneys, as is shown in this case.

Tubular nephritis often assumes a chronic character from the start. It seems to originate of itself. Sometimes it is attributed to wet and cold or other unfavorable surroundings.

When we have the chronic tubular disease, we have also hypertrophy of the left ventricle of the heart. The increased size of the heart seems to be brought about by the obstruction in the renal arteries.

The kidneys are a very vascular structure. The renal arteries divide and subdivide, and form the vascular tufts of the glomeruli and form arches between the medullery and cortical structure of the kidney, and form a plexus of capillaries around each tubule, of which there are about 500 in number in each kidney.

When the structure of the kidney is swollen by the presence of inflammatory products it offers more or less resistance to the free circulation of the blood through the renal arteries.

If the circulation is maintained, there must be an increased pressure in the circulation in the arteries, and, in order to main-

tain the increased pressure, the left ventricle of the heart is called upon to do more work; hence its increase in size and impulse as we have in this case.

Under the stethoscope we find the impulse of the left ventricle stronger than usual and its area increased. We find it too far over to the left side.

While we find the impulse of the left ventricle increased, we do not find a corresponding increase in the pulse, but the action of the pulse is quick and feeble.

Whenever we have obstruction to the circulation we also have dropsical accumulations in the cellular tissues. Where we have altered nutrition of the vascular cells of the vessels we have the tendency to fatty degeneration with the liability to exudations of serum into the cellular tissues. In the chronic form of Bright's disease the whole of the kidney is not uniformly affected. While some of the tubes are being blocked by fresh inflammatory deposits others are undergoing disintegration of the epithelium with an abundant exudation into the urinary tubules. As the disease continues, the vascularity diminishes and the vitality of the cells is more and more impaired and they undergo retrogressive changes.

There is no difference between the acute and the chronic form of the disease, only that in the chronic form nature makes an effort at repair and more time is required for the changes to take place in the reconstruction of degenerated connective tissue cells, which is a lower form of structure than the normal structure. While some tubules are being reconstructed in this way, others are undergoing atrophy and degeneration until the whole kidney is involved, while the patient succumbs to a general breaking up of the walls of the blood vessels.

As the disease advances in the chronic form, fatty cells are gradually increased in amount as the degeneration proceeds.

Prognosis.—If the patient is to get well, the fatty stage may pass off. The degenerated cells may be carried away by the urine. Those which remain are absorbed. The retrograde process gradually ceases and the cortex of the kidneys returns to the normal condition; if not, the degenerative changes continue, the kidneys become diminished in size and changes in the intertubular connective tissue take place. In this case the prognosis is probably *esse malum.*

Treatment.—Milk diet, tincture of ferri chloridi, fifteen drops three times a day after meals, and strychnine one-fortieth grain three times a day after meals. For pyrexia at night four grains phenacetin at bed-time. The iron is for the purpose of overcoming the anæmia; the strychnine gives tone to the heart and nervous system; the phenacetin lowers the temperature and produces perspiration, and a diversion from the kidneys to the skin. Under this treatment the urine has become more copious, with less albumen and an increase in strength.

Pelvic Presentations and Their Management.

Read before the South Kansas Medical Society at Newton, Kansas, November 15, 1892.

By H. L. McILHENNY, M.D., Norwich, Kas.

This is a subject of such great importance that every practitioner should be posted as to the proper line of treatment. In the discussion of the same I do not expect to present anything new, but to review the subject and relate some of my experience, extending over a period of seven years. Unlike many other branches of medicine, the nature of such a case, falling into the hands of the obstetrician, is somewhat a matter of chance, and at no time can he feel sure that his very next case will not be one involving the difficulties of an after-coming head in the pelvis.

Under the head of pelvic presentations all the cases where the lower extremities of the child present are usually included, which may be breech, footlings or knee presentations. While it is of some importance that the physician should be able to recognize the presenting part, in so far as the mechanism and management are concerned, they are almost identical. Pelvic presentations are not at all infrequent, yet their frequency

is variously estimated by different authorities. Those in which the breech alone presents being the most frequent. According to Churchill, one in fifty-two cases; while others say it occurs more frequently, or once in thirty-five to thirty-eight cases. Footlings occur once in about ninety cases; knee presentations being extremely rare.

In my own experience I have found pelvic presentations occurring more frequently than recorded by any statistics with which I am acquainted, extending over a period of seven years. Have attended on an average about fifty cases of obstetrics each year, and during this time and of this number seventeen were cases of pelvic presentations. In all of them the breech presented, except one, which was a footling. Hence it will be seen that the ratio of breech presentation in this set of cases is much greater than that of most authorities. I have never met a case of knee presentation.

The causes of pelvic presentations as yet seems obscure. To my mind, however, it seems plain that some peculiarity exists in the shape of the uterine cavity in certain women, for I have attended a lady in two successive confinements, both of which were breech presentations; and I learned that two years after I last attended her she again had another breech presentation. The final result of these cases, as regards the mother, are not more unfavorable than in vertex presentations. The first stage of labor, however, is usually tedious, as the rounded breech does not adapt itself to the lower segment of the uterus as does the head; hence dilatation goes on slowly. The results as to the child are quite different.

Churchill estimates the mortality as one to three and one-half. This is certainly too high a death rate; at least it is not consistent with my own experience, and is greater than should occur in the hands of the careful physician, if properly managed. However, the risk to the child is great under the most favorable conditions.

In the seventeen cases above cited, I had but two (2) deaths occur before delivery could be completed. The causes of this mortality are conceded to be due to pressure on the umbilical cord in the interval elapsing between the birth of the body and that of the head. At this time the cord is compressed between the head of the child and the pelvic walls, thus arresting the circulation of its vessels, so that there is an imperfect æreation of the fœtal blood. Pulmonary respiration not being established, the child is asphyxiated. Another condition may exist which will produce a like result, viz.: that the placenta is often separated by the uterine contractions when the body of the child is being expelled, thus producing an arrest of placental respiration. Indeed, this I believe to be a more frequent cause of death to the child than compression of the cord; at least in the two fatal cases in my own experience this condition existed. By some authority another cause of danger to the child is the compression of the placenta between the contracted uterus and the hard fœtal head, thus arresting the function of the placenta. With this theory I cannot agree. It looks unreasonable to suppose that a placenta, which has not been detached, should have its function arrested by reason of a contracted uterus. If this were true we might expect a very great mortality of whatever presentation. It should not be forgotten that there is greater danger to the child in footling than in breech cases, for the reason that in the former the maternal parts are less perfectly dilated and the birth of the head is more likely to be delayed. As to the mechanism of these cases but little need be said. The simplest division in which the breech is described is that of four positions similar to those of the vertex, viz.: first, second, third and fourth. In these positions the presenting parts (or breech) are subjected to about the same forces as in vertex presentations, yet the changes of position in the breech in its progress is less uniform than that of the head, on account of its imperfect adaptation to the pelvic cavity.

In the first position — left sacro-anterior — the sacrum of the child points to the left foramen ovale. As labor advances, the pains acting on the body of the child, the breech is gradually forced through the pelvic cavity, its progress being as a rule more

slow than that of the head, until the lower strait of the pelvis is reached, when about the same rotation takes place, as in cases of the occiput. By some this rotation is denied, but there is no doubt that it does occur in the majority of cases. The left hip now becomes engaged behind the pubes and the right toward the sacrum; at this point a motion similar to extension seems to take place, the right hip rotating slightly and distending the perineum, and is expelled; the left hip soon following. When the hips are once born, the feet soon follow, unless the legs are extended on the abdomen of the child. The arms of the child are sometimes found on the thorax of the child, yet they are more frequently extended over the child's head, in which case there is an unavoidable delay and an increased risk to the child.

To correct this trouble we should be cautious, and every move should be made so as to favor the natural motion of the joints, lest we fracture some of the bones of the arm. The finger of the attendant should be introduced to the posterior, as there will be more room toward the sacrum, and carried down to the elbow, where it can be drawn over the face and outward, and the forearm liberated. A similar procedure should then be used in liberating the other arm. This done, the shoulders soon follow. By some we are told that the arms are seldom ever extended over the head unless some traction has been made in order to hasten delivery. My own experience does not justify this statement. I have found that unless we have a small child and a large pelvis the extension of the arms—one or both of them—will take place six times out of ten, even though the expulsion of the child is left entirely to nature's powers. When delivery of the hips has taken place, I am well aware that the temptation is strong to make traction and hasten delivery, but the wise physician withholds his hand, thus avoiding unnecessary trouble. The arms and shoulders being extracted, the delivery of the head is now of the greatest importance, as the safety of the child depends on a speedy delivery of the head. While the danger to the mother is not great, the life of the child is in jeopardy every moment, and one or two minutes may decide the question of life or death, caused by compression of the cord and interrupting fœtal circulation, as also by a premature separation of the placenta. Some one has suggested that where delivery of the head could not be effected at once to establish pulmonary respiration by passing one or two fingers into the vagina and pressing it back to admit air into the child's mouth. This procedure in my hands has been a failure. It wont work. To assist nature in completing birth of the head is the one thing necessary now. Supposing the face to have rotated to the cavity of the sacrum, the first thing to do is to carry the body of the child well up over the pubes and abdomen of the mother without making traction or interfering with flexion of the chin on the chest. In many cases this will be sufficient to complete delivery. Unhappily all cases are not so easily disposed of. Should there be a delay now, traction must be used, but applied in such a way as to insure flexion. Keeping the child in the same position, the index and middle finger of the right hand are placed on the back of the child's neck and push the head into a flexed position; then by passing the index and middle finger of left hand on the superior maxilla or introducing the index finger into the mouth of the child, delivery will be completed without further trouble in the majority of cases. A valuable adjunct to hasten delivery of the head is pressure through the abdomen, which should be used at the same time that traction is being used. This combination will seldom fail. Many authorities advise the application of the forceps to the after-coming head where any delay in the birth of the head takes place. If the delay be due to lack of expulsive force in a pelvis of normal size, the manipulation just described will be all sufficient in almost every case. The indications for the use of the forceps might be found in the following conditions: Where a disproportion exists between the size of the head and the pelvis; when the head is in the superior strait and the chin to the front; in rigidity of the soft parts; in too large heads, as hydrocephalus.

In such cases as these, by the judicious use of the forceps, many dangers may be obviated. The indiscriminate use of the forceps in all cases is not good practice.

Laryngitis, with Report of a Case.

(Read before the Republican Valley Medical Society, April, 1892,

By S. C. PIGMAN, M.D., Concordia, Kansas.

It is not my intention to discuss the different diseases of the larynx, for your experience and text-books have made you familiar with them. A history of the case furnishes the text of this paper, and while there may be a dearth of originality in the management it proves that good results come from old methods, and that the "flower safety may be plucked from the nettle danger," and life saved by surgical interference in most unpromising cases.

Dr. F. A. McDonald, of Aurora, in whose practice this case occurred, has kindly furnished me these notes.

Mrs. Clara Brown, aged twenty years. Patient consulted me February 17, 1891. Is hoarse; no cough. Prescribed ammon. chlor., syr. ipecac with solution. February 26: Voice improved; no pain or tenderness over larynx. Ordered medicine continued. March 20: Patient confined to-day; child born before I arrived. Says she has not entirely recovered from her cold. Is still hoarse; has neither dyspnœa or dysphagia or cough. There is slight tenderness over larynx. Former prescription was refilled and spray of ammon. chlor. grs. v to ʒi ordered. March 24: Did not see patient; some respiratory difficulty reported. March 26: Temperature 100 F., pulse 120. Inspiration and expiration embarrassed; some cough, dry and abortive in character. Prescribed quiniæ sulph. grs. iv every three hours and the following mixture:

℞

Potass. brom	grs. x
Ext. ipecac fld	m v
Tr. aconite	m ii
Syr	q. s...ʒi

M. Sig.: A tablespoonful every two hours.

March 28: Temperature 100 F., pulse 130. Breathing still embarrassed; general condition unchanged. March 29: Respiration comparatively easy. Rested well last night. Other symptoms unchanged. March 30: Improvement continued until this evening, when she became rapidly worse. March 31: Temperature 100½, pulse 120; very restless and dyspnœa increasing. April 1: Pulse 140, temperature 101; symptoms unchanged, sleep much broken and patient weaker. April 2: Pulse 140, intermittent; temperature 100 4-5. Respiration very difficult, voice whispering, cyanoses marked. April 3, 2 A.M.: Pulse weak and intermittent; symptoms of carbonic poisoning increasing; can be aroused with difficulty. Tracheotomy performed at 2:15 A.M. Tube obtained and introduced at about 12 o'clock same day. Pulse 130, temperature 100 4-5. Patient brighter. Liquid nourishment and stimulants ordered. Temperature of room to be kept uniform at 75° F., and atmosphere moist. A capsule, containing quiniæ grs. ii and phenacetin grs. iv, to be given every four hours, and a teaspoonful of the following mixture every two hours:

℞

Potass. brom	grs. xv
Ammon. chlor	grs. v
Tr. digitalis	m v
Syr. seneg	ʒ ss

M.

April 4: Pulse 120, temperature 99½ F. Expectoration abundant and patient fairly comfortable. April 5: Pulse 100, temperature 100 F. Takes plenty of nourishment; auscultation reveals signs of bronchitis. Treatment continued with addition of counter-irritation over sternum. April 6: Pulse 100, temperature 101 F. Bronchitis seems aggravated. Patient rests well and continues to take nourishment. April 7: Pulse 100, temperature 101 F. Expectoration abundant and patient stronger. April 8: Temperature and pulse same. April 9: No change in symptoms. Strength improving and treatment continued. April 10: Pulse 98, temperature 101. Bronchitis subsiding; tongue clearing. April 11: Pulse 92, temperature 100 4-5. Closed tube to note

improvement in stenosis; can breathe naturally, but with difficulty. April 12: Pulse 92, temperature 100 F. Patient continues to improve in strength; no change in treatment. April 13: Pulse 100, temperature 101 F. Parotiditis, which had been slight for several days, now well marked; both glands much swollen, tender and painful. Prescribed—

℞

Potass. iodide .....ʒ ss
Ung. stramonii.....ʒ i

to be used externally freely.

Internally, wine-glass doses of wine of coca instead of whisky every three hours, and five grains of phenacetin every four hours.

April 14: Pulse 105, temperature 101½. No improvement in parotiditis; other symptoms better; treatment continued. April 15: Pulse 76, temperature 99 4-5. Parotiditis subsiding; respiration easy. April 16: Pulse 100, temperature 100½. Increase temperature due to omission of phenacetin. Respiration easy. Breathes with tube closed for from five to ten minutes without complaint. Parotiditis subsiding. April 17: Pulse 105, temperature 101. Can breathe with canula stopped for one-half hour. Other symptoms all improving. Rise in temperature probably of emotional origin, her baby being dangerously ill and dying. April 19: Symptoms about same as 17th; more resigned to loss of her babe and strength improving. April 21: Temperature normal, pulse 95. Parotid inflammation nearly gone; appetite good; sleeps well; expectoration diminishing; breathes easily with tube removed and wound closed. April 27: Removed tube; closed wound by drawing together with adhesive plaster. Respiration free and easy. April 28: Patient rested well previous night; breathes without difficulty. Wound is healing rapidly. April 30: Respiration good; wound closed except a small sinus where tube was inserted. Patient discharged.

The history of this case is that of catarrhal laryngitis, modified by pregnancy and treatment. That the puerperal period, with its altered blood tendencies to stasis and hypertrophies protracted the affection and gave it the impress of gravity which after delivery it assumed, is unquestioned.

Beginning as a slight catarrh of the larynx, it progressed through the various stages with exacerbations and declines until it merged into laryngeal œdema. At the time of our consultation the nervous shock and unequal respiratory contest had well nigh exhausted her. The fierce anxiety for more air had subsided with the increasing mental hebetude; the pulse was small and intermittent; she was unable to breathe in recumbent posture; her lips were livid, voice suppressed, and could be aroused only with difficulty. That the laryngeal stenosis demanded immediate tracheotomy to relieve the dyspnœa was the conclusion readily reached, and, the husband consenting, performed. The details of the operation are so well known that they need not be repeated. In no way did we depart from the usual operation, but in the absence of a trachea tube or retractors a ligature was inserted at each side of the opening in the trachea and tied at the nape of the neck, securing the opening in the trachea in the same manner as the lead foil retractors, used and advocated long ago by Joseph Pancoast. After the operation, which was conducted under anæsthesia, there was immediate relief from the dyspnœa and improvement in the circulation. Large quantities of mucous were ejected from the tracheal wound with increasing relief to the patient. Liquid nourishment and stimulants were ordered, a thermometer obtained and directions given to keep the temperature at a uniform height of 75° and the atmosphere moist.

THE tablet-triturate form of preparing medicines bids fair to do away in a large measure with the physician's dependence on the drug store. The physician can now prescribe at the bedside or at the office in the most palatable and accurate form for almost any ailment without recourse to outside sources. This will shortly settle the voracious counter-prescribing question.

SOCIETY PROCEEDINGS.

The Topeka Academy of Medicine and Surgery.

Academy met in regular session, Monday evening, December 12, 1892.

Dr. S. E. Sheldon in the chair.

Dr. D. F. Rodgers was elected to act as temporary secretary.

Present: Drs. O'Brien, Lewis, Stewart, Magee, McCrea, Barnes, Conger, Klemp, Gilbert, W. E. McVey, Sheldon and Rodgers.

Paper by Dr. O'Brien on "The Present Status of Medical Legislation."

DISCUSSION.

Dr. Stewart.—"This is one of the leading questions—the subject of control by legislation of medical practice. The summary given in reference to schools is very interesting. I can add nothing to the doctor's conclusions. We all have opinions on this subject. It has been my opinion that the control of practice lies with the honorable members of the profession. The higher requirements are coming in. Three and four year courses are being adopted instead of two. I saw a statement in reference to the three-year course, made at the Southern Association meeting, claiming this would ruin them financially. This is the rock upon which it splits, *i. e.*, the financial point. New York took a backward step a few years ago. The purification of the ranks of medicine rests with the individual members. It has been my habit, when a student presented himself, to discourage him if he had not the proper qualifications. It is true that many with only a glimmering of knowledge have succeeded, but we should discourage such from beginning. We do need laws of this kind in Kansas. I think the law formulated by Dr. O'Brien is a good one. I do not think the last one read would be practicable. We cannot get all we want."

Dr. Magee.—"I think the law read at the last is too lengthy and too cumbersome to get through. I think what the doctor has proposed is the proper thing to do. The legislators think when there is a physician present that there is a scheme on foot which will give some one an advantage. The registration act proposed would make the law on the statutes more effective. Our endorsement should be given or a committee appointed to take the matter in hand."

Dr. Rodgers.—"It strikes me that the profession are the proper persons to take hold of it. Dr. O'Brien says we should have a law requiring all physicians to register. It seems to me we have a law of that kind now, or it has been required of physicians in some parts of the state. When I came to Kansas in '81 there had been a law passed very similar to the one read. The trouble with it was that a board of examiners were to be appointed to pass on men with diplomas and those who had not. A fee being required for one and a larger fee for the other. The faulty part of it was the fee charged for registering a man who had a diploma. If a law such as that was passed, then it can be now. Dr. Pollock's law meets my approval except in the fee for having a diploma."

Dr. Klemp.—"The defective part of the old law was that the board was not appointed by the governor."

Dr. Rodgers.—"The medical profession don't seem to know that we have had these laws. The dentists and pharmacists have had for a number of years a law requiring a man to be registered to practice. This law was fathered by the medical profession, yet we have not succeeded in our efforts."

Dr. Lewis.—"I wish to commend the paper of Dr. O'Brien. I am in favor of anything that will benefit the profession. I think a law should be considered until it is exactly right. The registration law was enacted by the board of health. I have heard we had an effective law, but my own idea is we have no law."

Dr. Gilbert.—"I am in sympathy with the law, but do not exactly like one part of the law for registration proposed—*i. e.*, that a man can only register in one county."

Dr. Conger.—"I think with Dr. Stewart

that the remedy lies with the profession. Adopting three and four-year courses will not correct it unless all the colleges adopt it, as men will naturally take the shorter course, and the matter must be regulated by some legal restriction. I prefer the registry act to the law of Dr. Pollock."

Dr. O'Brien.—"There is no one who has less of a personal interest in the outcome of a medical law than myself. I have a personal pride in the medical profession. I have no pet measure, but presented these points to bring out a discussion. I think these matters should be thoroughly discussed before the meeting of legislature. The law now on the statute has been sufficient to drive out of the practice several physicians."

Dr. Rodgers.—"While I was a county health officer there were doctors who would not register nor report, and Dr. Redden informed me that they could not be compelled to. The state board of health have no authority and we have been bulldozed by a board which has no authority to enforce the law."

Dr. Warner thought Dr. McLallen would have more influence with the legislature than any other man; and that if the profession would unite upon a plan they would get his entire support. He would be greatly interested in anything which would advance medical education."

Drs. Warner, O'Brien and Sheldon were appointed a committee to wait on Dr. McLallin and invite his interest in the matter.

A motion by Dr. Conger, that the president call a meeting of this society and invite members of the other schools to attend, for the purpose of having a general discussion on medical legislation, was carried.

South Kansas Medical Society.

[MEETING OF NOVEMBER 15TH CONTINUED.]

Dr. G. Boyd proposed the name of Dr. S. E. Sheldon for honorary membership. The same being favorably considered, he was elected.

In the discussion of Dr. McIlhenny's paper, Dr. Sheldon said: "The doctor has given us a good explanation and one which I am inclined to accept—*i. e.*, the formation of the pelvis. It called to mind a woman who had five successive pelvic presentations (otherwise a healthy woman), and I think we find these presentations are apt to recur a second and a third time. Where forceps can be applied they should be used. The doctor's plan of pressing occiput up and bringing down chin is the proper treatment, but I think even in these cases forceps are best used."

Dr. Harris.—"My experience is that a pelvis does not change much after maturity. All my cases have occurred after other normal presentations. I am surprised at the number of these cases found by the physicians. I concur in the manner of delivery."

Dr. McIlhenny.—"Three of the cases I reported were primipara, and this seems a further reason why we should expect some pelvic trouble."

Dr. Lindsay, chairman of the committee on the case of paralysis, reported as follows: "This man, an Englishman fifty-one years old, four years ago began to have a feeling of numbness in right hand; previous to this he had a spell of typhoid fever. He had lived in southern Illinois and had fever and chills. He was exposed a great deal. Numbness extended to the arm and finally to the whole side, and to the other side and all of the body. He worked very hard, was much overdone and exhausted. He had at first pain in the bowels below the umbilicus, continuous except when using anodynes. This continued for six months. As the tremulousness increased, the pain diminished. We find normal sensation of the skin and muscular action good. The knee jerk is somewhat exaggerated, but because of the stiffness of the muscles of the leg. The pupil of the left eye is larger than that of the right. You notice the effort and stooped position in walking; the tremulous mouth and position of hands and thumbs; and that when he sits down it is with a jerk. The muscles of the face seem stolid and expressionless. We find that contrary to custom he has in-

herited this condition. His father has had the same trouble for twelve years. On the least excitement he is more agitated. The tremor in these cases is usually controlled at first. We find he can in a measure control it. When he sleeps, the tremor stops, though he does not sleep quietly. The case has already been diagnosed as paralysis agitans. We have one disorder to exclude—multiple sclerosis. While we have not the pain of the latter, we do have the prominent symptoms of paralysis agitans. It seems a clear clinical case of this disease. The inheritance is very unusual. The pathology of this condition is very much disputed or there is a variety of pathological conditions. We find, in some of the examinations made, some parts of the cerebrum are diseased. The pons, corpus striatum, medulla and the columns of spinal cord have all been found to be the seat of the lesion. The motor tract is not disturbed."

Dr. Klippel asked if there had been any examination of the urine or test of the vision.

Dr. Lindsay replied in the negative. Continuing, he said: "This is one of the sad conditions in which we are unable to do anything. Recorded recoveries are rare, though some are reported from the use of galvanism, hyoscyamine, etc. I have never seen one recover. They can be made more comfortable. The cause of this disorder is a question. Over-work has a great deal to do with it. I saw cases in New York among young men who are doing a great deal of study. One man who is a specialist in nervous diseases. Inasmuch as we have such a variety of pathological conditions, it seems it may come from degeneration of the brain or columns of the cord, from over-work or exposure; anything which interferes with their nutrition. In some cases no seat of lesion could be found. As to treatment, I think central galvanism, 1-100 grain doses of hyoscyamine, increased to 1-12, or hydrobromic acid are all good."

Dr. Axtell.—"The treatment given has been principally fifteen to twenty amperes of the galvanic current. There was no benefit and it was discontinued."

Dr. Harris.—"A case I treated some time ago was improved by oxide of zinc and fluid extract hyoscyamus."

Dr. Peak.—"I had a case which I diagnosed paralysis agitans and treated accordingly with good results apparently, but with relief of the tremor, headache began. We learned later that we had a tumor on the left side of the base of brain. This has not yet been verified, as the man still lives. This opinion was given by Dr. Lyman, of Chicago. I thought at first it was a clear case of paralysis agitans."

Dr. Klippel.—"I was interested in this case on account of the case referred to me. In this case, on ophthalmic examination, I found choked disc. Also of a friend of mine, who has all the symptoms of paralysis agitans. He has been a very close student. I am mostly interested in the prevention of these cases. If we could see the approach of these troubles we might prevent by changing the habits. The intense application of students is the most serious factor. In the case of Dr. Peak there was tumor of one side only."

Dr. Halley.—"I fully agree with Dr. Klippel in one sense. In the case presented here the idea that it was caused by study requires a vivid imagination. The point behind it is that there is a change of structure of tissue going on without proper elimination. The history of over-work and typhoid fever serve the same purpose as the over-study. It is a degeneration of nerve tissue, caused by the retention of some elements which should be eliminated."

Dr. Lindsay.—"I simply wish to call attention to one point, *i. e.*, the fineness of the tremor, which is a diagnostic sign. In the tremor of lateral sclerosis we don't have this fine tremor. I did not wish to give the impression that this was brought on by over-study. But the over-work in connection with his ill-health make up the necessary history."

The next paper was on the subject of "Eye-strain and Headache," and presented by Dr. G. A. Wall, of Topeka.

In the discussion following the paper, Dr. Klippel said: "I listened with interest to the paper because I believe he has presented

a prevalent cause of headache. I think we who study in a special line are prone to overestimate this as a cause. There are other very prevalent causes of headache." The doctor referred to a case where an oculist, after repeated trials, failed to relieve the headache by glasses. A gynecologist located the pain at the top of the head, and on examination proved it to be an erosion of os. Treatment relieved the headaches. "I heard a gynecologist state that seventy-five per cent. of headaches were due to menstrual disorder. I think we are prone to overestimate the percentage in these cases."

Dr. Minney.—"We must not forget that with the ordinary hygiene and light of the school-room the eye, even when normal, will complain, and we have to give help to tide them over. When out, they get along without help. We should carefully examine the eye. We may find an error of refraction, but we should not stop unless complete relief is afforded by glasses, but examine the whole body. In respect to mydriatics I differ from the doctor. I have a tabulated report of forty of the American oculists. Of those some of the most prominent use atropine sparingly, while others use it more. I find that by long-continued reading in the office and repeated trials I can get along without it in the majority of cases. It is no wonder that headaches are produced by eye-strain when we remember the close connection of the eye with the brain. In fitting glasses, where there is long-continued hypermetropia, the muscle is hypertrophied and we should not correct the error completely."

Dr. Oldham.—"These cases of eye-strain come under the observation of the general practitioner, but I do not attempt to treat them. Where they are in good health and no indication of any other trouble but eye-strain, I send them to an oculist, and there is usually relief. The gynecologist attributes headache to uterine disease because a large per cent. of patients going to him have uterine trouble. Comparing the children now with those of years ago I wonder how they were treated then."

Dr. Lindsay.—"It is not surprising that we have headaches from eye-strain when we consider the extent of the optic tracts. I do not believe there were so many of these cases twenty or thirty years ago. I think, from our habits and methods of education, there is a tendency to degeneration of tissue. We should warn our patients against this intense application and worry."

Dr. Purdue.—"Dr. Lindsay has struck the key-note. Most of us twenty or thirty years ago only went to school sixty days in a year. I think our children are overworked."

Dr. Cordier.—"I take exception to these views. I believe in proportion to the population there were as many headaches then as now. The result of education is that they seek the specialist for relief. Children are sent that we formerly would not have known of. It is useless to say we have more cases of salpingitis now than formerly. It is folly to think there were none of these cases before Tait first diagnosed and operated on one. It is the result of education."

Dr. Minney.—"Dr. Cordier is right to a certain extent. Dr. Purdue and Dr. Lindsay are also right. Why is it we have so few of these cases from the country? They are not so closely confined. The reports of these cases in Germany show the result is the same."

Dr. Halley reported for the committee on the case of cyst of orbit. He said: "The history of this case goes back about nineteen years. She was fond of horses and when fondling a horse's head was struck on the orbit; at a later time was also struck on the nose. You will notice the supra-orbital ridge on this side is larger than the other. The greatest pain and tenderness is over the supra-orbital nerve. The enlargement is like an induration, extending around to the nasal process of the superior maxillary. There was a great deal of swelling a year ago. It was operated upon; the tumor being opened up, but no pus was found. On the 6th of last May, Dr. Axtell opened it up and found a sac which discharged freely of pus. The upper wall of the cavity was long and he could thrust his finger two or three inches back into the orbit. The wall of the sac being thick and bony indicates that the

trouble is of long standing. The fact that the wall of the sac contained bone indicates that it began as a periostitis. There is an exceedingly small opening now in which you see the tube. It will not heal as it is and the use of antiseptic washes, tr. iodine and such applications have failed to make it heal. It fails to heal for one of two reasons—either there is a bony surface which refuses to granulate or there is dead bone. It should be opened up, the bony wall of the cyst should be cut away and the cavity washed with a solution of chloride of zinc. This destroys infection and infected tissue better than other antiseptic solutions. A ten per cent. solution is strong enough for all practical purposes, and in most cases five per cent. is enough. The cavity should then be wiped out and packed with gauze, dressed lightly and antiseptically, and should be washed with a 1-200 solution chloride of zinc. It cannot be kept aseptic with the tube, and it cannot well be dressed as it is. The operation would not injure the eye. The incision should be made up and not down. There has been no odor or discharge from the nostril."

Dr. Boyd.—"I was present at the last operation when pus was found. I did not anticipate that the bone was affected, though it seems it ought to heal unless there is some deep-seated trouble. It is my opinion that the bone is not affected."

Dr. Axtell.—"There was no odor, at any time, of dead bone. When we cut down, going outward and upward, we first found a bone plate with blackened edges and an opening hardly large enough to admit my finger. I cut the bone away and found a sac which seemed to be a cyst wall, which I opened, and under this a delicate membrane which, on being touched, ruptured, and allowed the escape of several tablespoonsful of pus. I introduced my finger nearly its whole length backward and outward. The eyeball has gradually been going back to its normal position. The bony parts of the cyst wall seemed to be close to the outside and partially to cover it. The place where the bone and cyst was is all filled up. It runs a very little, perhaps two drops a day, but it will not heal. The bony formation was not a natural bone; it was a growth from the nasal and lacrymal bones."

Dr. Boyd.—"I do not think that was a bony growth, though there was more or less calcareous deposit over the abscess, which was deep down in the orbit. We did not find any disease of the bony orbit."

Dr. Axtell.—"Since I have seen the case the lacrymal sac has not been diseased and has been doing its work."

The address of the retiring president, Dr. L. S. Hall, was very interesting and scientific, full of advanced thought, and showed a careful and systematic study.

In the discussion of the paper, Dr. Sheldon said: "The paper is full of advanced thought. I am not ready to admit that inflammation is always accompanied by suppurative action. I believe we may have an inflammatory process of repair without pus. To have pus you must have certain elements which you do not always find in inflammation. I believe inflammation and repair are synonymous; that inflammation is a physiological and not a pathological process. Where there is a pathological condition you have a condition of destruction, not of repair. In inflammation or repair you have redness, pain and swelling. In every process of repair you have an increase of blood, serum, immigration of leucocytes and a condition of swelling. These leucocytes are necessary to the development of the karyokinetic process or construction of new tissue. They give nutritive material to the new embryonic cells and also act as phagocytes to the germs which might destroy them. No matter how small the injury, the process of repair is the same, each tissue reproducing itself. If the wound is kept free from pathogenic germs you will have a simple reparative process and not destruction. I can draw no distinction between the process of inflammation and repair. Behind your suppurative process you have a reparative process or inflammatory process which prevents the further invasion of the pathogenic germs. In regard to one other section of the paper: I am hardly yet prepared to say that tuberculosis is hereditary. I believe your patient

is born with a lack of resistance to the infections or diseases. If our theory is correct, that tuberculosis is due to a specific germ, it cannot be transmitted from parent to child."

Dr. Halley.—"I commend the paper for the amount of painstaking work. It is deserving of the warmest consideration. One or two points might be brought out more clearly. The latest bacteriological investigation shows that no disease is transmitted so that it forms a part of the individual except by infection. It is an infection of the sperm cell of the father or mother. It is not a likeness of cell growth and in the characteristics of father or mother, but the carrying of an entity by the embryo cell as an actuality. Dr. Sheldon brought out another phase of this idea—that is the deficient resistance that is established by the parent or by a blow which may produce a local lack of resistance. The parent with a feeble organism begets a feeble organism. In one case an inherited vital weakness, in the other a feeble resistance, as a result of a blow. We know more about the tubercle bacilli because it retains the stain more readily than other bacilli. We will soon get something to stain all the bacilli; then we will know what produces each of them."

Dr. Lindsay.—"It occurs to me that the germ of syphilis has already been demonstrated."

Dr. Hall asked for Dr. Halley's opinion of inflammation.

In reply, Dr. Halley said: "My notion as derived from current literature is that the inflammatory process is always one of infection. The initial stage up to the point of destruction is all we have now (*i. e.*, the determination of blood) of what we once called a reparative process. Repair goes on in the surface of the wound into the tissues that have been divided. If the wound is clean, all we have is the active determination of blood. The new cells are thrown out and repair is perfect, except where we get suppuration. Inflammation is the accident of surgery."

The following resolution was introduced: "*Resolved*, That stated meetings be held on the first Tuesday in May and November in some established place of meeting."

On motion, the resolution was laid on the table.

Hutchinson was selected for the next place of meeting.

The society proceeded to elect officers for the coming year, and the following were elected:

Dr. Axtell, of Newton, president; Dr. Klippel, of Hutchinson, vice-president; Dr. Peak, of Pratt, second vice-president; Dr. O. B. Whittecar, of Peabody, secretary; and Dr. C. C. Furley, of Wichita, treasurer.

The evening session was held in the parlors of the Clark House.

Dr. Halley presented the following case:

"This young man gives this history: Four years ago he first saw a swelling in the right groin. There was no pain at first. The swelling gradually increased in size. He first saw a physician in regard to it two years ago. It has never been strangulated, though it descended entirely into the scrotum, and is a complete oblique hernia. It now presents a large hernial ring without descent. During the past four days he has been able to retain the hernia within the external ring. This is a part of nine days during two years which he has been able to do so. The truss he is wearing now is over the external ring and symphysis pubis. While this holds the hernia inside the external ring, it does not prevent strangulation or extrusion. He has been wearing this truss over the extruded hernia with the hernia in the scrotum. By pressing the finger up you will find a large ring. It may be now that it is retained by a fold of omentum. The act of coughing makes it protrude into the canal. He is now twenty-four years old. It is a constant menace to his existence. It is a wonder that it has not become strangulated and inflamed. The tendency is to induration, which will prevent a return of the hernia. They sometimes slough off and still the man may live. This man is too young to run the risk of a blow here, producing an inflammation of the protruded mass and acute strangulation. If he were over sixty years of age he could take

more care of himself, and I would advise him to let it alone, but adjust a different truss. With this hernial sac it is impossible for him to succeed at any ordinary business. A complete cure is possible for him. The operation recommended by the committee was to allow complete extrusion, lay open the abdominal wall and dissect the sac loose from the surrounding tissues, holding with forceps while you return the contents of the sac by manipulation. You now have a condition similar to a pocket turned wrong side out. Now make a longitudinal incision, carefully feel inside, separate the adhesions and return any intestine that may remain. Having it now well opened, take a long, curved needle, armed with silver wire No. 20, carry it through the abdominal wall into peritoneal cavity, then forcing it through on the other side of the wound you have made. You will have four silver sutures in the wound puncturing the muscles which form the pillars of the ring. After cleansing thoroughly, go through with catgut suture and tie clear across the neck of the sac and cut off the redundant mass. In suturing, use the interrupted suture, going back a little each time. Heavy catgut should be used. In cutting off, leave one-half inch of the sac beyond the point of sutures. Push this into the wound and thus fill up the aperture. Now with a long, curved needle pass through as if you would close up, passing down through skin, fascia and pillars of the rings, about one-half inch apart, until you completely close the wound. You have now four stout silver wires outside of everything; now pull them up tightly. Operations of this kind are nearly always successful. Leave the wire in two or three weeks. Take the silk out in ten days. The danger and trouble is in keeping the patient in bed. It is a mistake to think that when a wound heals aseptically it needs no more care. It takes the tissue a certain time to perfect itself. The wound closes and looks alright, but it is not. It is provisional tissue then, not normal tissue cells; they are exudated corpuscles. It takes four weeks for any wound to heal perfectly. It may be strong, but there is a process of change from provisional cells to normal tissue, and it is not perfected till this change is complete. This is a safe operation and easily done. If kept aseptic there is no danger of suppuration."

Dr. Sheldon.—"I like the operation with the exception of the idea of fastening the peritoneum to the abdominal wall. It is not a natural condition. Another objection is, where he doubles the peritoneum together he leaves a place where the intestines may form a new sac. We should leave the wall as smooth as possible. Instead of fastening to the parietal wall, remove the surplus of omentum, because this may form a *cul de sac* for another hernia. If you remove this omentum and peritoneum, and suture as suggested, and with purse strings or double suture, then return and you have a smooth surface on the inside. In closing the internal ring it should be closed separately and to itself. The McBurney operation differs in that he allows the whole to heal by granulation from the bottom. This is not strong tissue. The less new tissue you get the stronger your union. It adds to the strength to carry the suture down and close not only the internal ring, but the inguinal canal also. With the addition of this plan of treating the omentum and peritoneum I like the method suggested."

Dr. Halley.—"You misunderstood me in regard to returning the omentum."

Dr. Sheldon.—"In the case presented I think the man may expect a permanent cure. I never allow a patient to wear a truss after an operation, but have them wear a supporter or bandage. The truss will produce absorption of the new tissue."

Dr. Harris.—"I would advise an operation from my own experience. I rejected a case similar to this for insurance. The hernia became strangulated and he shortly died. A truss properly applied or an operation might have saved him. Another case in which the hernia was reduced by manipulation such an inflammation was set up as to produce a radical cure."

Dr. Halley.—"A man engaged as a bookkeeper in 1870 had been out on the road; was worried and came home with a colic. The

physician gave morphia, which did not relieve him. He found a small hernia which he reduced by manipulation. The man shortly after suffered from asthmatic attacks and occasional attacks of colic, but there was no hernial protrusion. Morphia relieved him. I saw him first about ten years ago. I found him vomiting dark, offensive stercoraceous fluid; pulse not very fast and temperature slightly elevated. The bowels had been confined for six days. I insisted on making an exploratory incision over the old hernia, believing the hernia had been returned *en bloc*. I was not permitted to do so then and on the next morning I found the pulse 140 and temperature 103½, the belly tympanic, stercoraceous vomiting, cold drenching sweat and pinched countenance. I operated at once. As soon as I had cut through the fascia and tissue, covering the canal, a knuckle of intestine popped out. I expected to find this, but not so soon. I dissected over it carefully, thinking I could shell the intestine out. Had to make an incision above and cut out from behind. The gut was black but not completely strangulated. By bathing with hot water the circulation was restored. The thick-walled sac was sutured as in the case mentioned before. By 12 o'clock the man had a free evacuation of the bowels and the vomiting stopped. He made a complete recovery and he was also relieved of his asthma. This was before McBurney's operation, and was carried out on simple common-sense principles. It is always dangerous to return a hernia that is strangulated."

Dr. McClintock asked if in case there were no adhesions of omentum he would cut it off.

Dr. Halley replied that he would not.

Dr. Sheldon thought that when there was a large hernial sac with excessive growth of omentum it would be best to cut off the surplus, as there is danger of a hernia forming in this sac of omentum.

Dr. Halley presented a paper on the "Treatment of Epilepsy."

He said: "That something can be done to relieve symptoms is true, but that a cure can be made is not. In regard to the pathological lesion of epilepsy: It was found that in certain cases there was depression of the skull with cicatricial tissue and a morbid condition resulting therefrom. It has now been definitely determined that all forms of epilepsy are due to sclerosed patches in the brain substance. I wish to call your attention to the possibility of surgical relief in a large number of cases. During the last year I have operated on a number of cases for the purpose of relieving symptoms. The success was quite marked, though they were not cured. The first case was two years ago last June. A man, twenty-eight years old; married; had two children; was a farmer and very dissipated. There was no connected history of injury, but there were prominent manifestations of a local central lesion. During a spree he had a fight, and says he was clubbed by a policeman. His scalp was cut, but it was not over the point where the epilepsy would indicate the lesion to be. The spells came on with convulsive movements of the right arm. He had both petit and grand mal. The attacks would occur five or six times a day. The mild attacks were much more frequent and consisted of a tremor of the right arm. The major attacks came on more violently, and unconsciousness readily supervened. I advised an operation for the removal of a large portion of bone from the right side of the head. I made a longitudinal incision, then a transverse incision and trepanned at the four corners of the space, and sawed out the piece of bone, which was four by five inches, and left it out. I then closed the scalp after slitting the dura mater, and put in two drainage tubes. The day following he had a great many seizures, but they were more like major attacks. On the fifth day he had no attacks and not until the ninth day. He then got out and drank some beer, and that night had a number of attacks. Twice after that when he got liquor he had seizures, otherwise he had none. In four weeks he was taken home, and since then he has had no attacks except when he got liquor.

"A boy, nineteen years of age, last March gave a history of an injury by a horse kick on left side of head at nine years of age. There was a depression behind the hair line

of the forehead. His right arm was practically useless, and smaller and shorter than the left. The right leg was smaller, but as long as the left. He was treated on the expectant plan when injured. Four years after the injury he had an attack of epilepsy well marked. In two months he had a second and in four months a third; then they became frequent, and finally he had a tremor of the hand, it assuming the flexed position. The petit mal consisted in a convulsion or tremor of the fingers and occurred every ten or fifteen minutes. I advised an operation. I made a large incision, cutting down over the entire area for forearm and leg; found the bone irregular and exceedingly thin. I cut out a large area of bone three inches square. Slit up the dura mater, closed down the scalp with drainage tubes in. In two and one-half weeks he left the hospital. For the first few days he had several attacks, but after ten days he had no more. Four or five weeks ago he had not had a recurrence.

"Have done some seven other operations. Some with a history of injury and some with none. In one case, where the injury was produced by a fall from a chair upon a sewing machine, there was no appearance of depressed bone. His attacks were peculiar. He had a feeling as if something were coming over his face, which was relieved by pressure. At night the attacks were well marked, coming on in his sleep, but the nurse could not tell where the convulsions commenced. The operation was done October 7th, removing a large portion of the skull, going entirely across the superior longitudinal sinus, being sure to go beyond any fracture that might have occurred from the fall. He recovered rapidly. Up to the past ten days had a few attacks, but since then has had none. In this case the pathological condition will probably be nearly permanent, and I did not expect much. From these cases I have concluded that these rules for operating may be made:

"First. In cases where an injury is determined to have occurred and when the convulsion corresponds with the seat of injury.

"Second. When there has been fracture of skull and convulsions do not indicate lesion at point of injury, then operate to cover point of irritation indicated by the convulsions.

"Third. When there is history of an injury to head without fracture, but convulsions show the lesion to be at point of injury.

"Fourth. When there is no history of injury, but the convulsions always point to one focal center; trepan over that point, removing a large portion of bone.

"The pathological conditions found are small, diffused sclerosed patches of brain tissue. Injuries produce these patches or a large area where inflammation has taken place. Where I find the brain tissue has been injured and adhesions of the dura mater, I not only remove the adhesions, but a portion of the brain also."

Dr. Lindsay.—"Operation in these cases, when caused by injury, is no doubt proper. It is doubtful if these patches occur in all cases of epilepsy. We have cases caused by eye-strain and relieved by glasses. They are not due to sclerosed patches. The first case of epilepsy which I succeeded in curing was one of disease of the pyloric end of the stomach, caused probably from continued eating of hard-boiled eggs. Correcting diet, counter-irritation, chloroform and amyl nitrite inhalations cured the case, and five years after, there had been no return. I do not think it necessary that there be these sclerosed patches in all cases. Relief of pressure of the brain, there being always a hyperæmia, would generally give relief. The local lesion in direct irritation I think would always be found in the motor area. All of the focal points referred to by Dr. Halley would be in the motor area. In all cases of Jacksonian epilepsy I have seen, the convulsion is first a tonic spasm. The cases cited seem to point rather to relief of blood pressure than the sclerosed patches. I understand he did not find the patches in these cases. I think the drainage tubes explain the recurrence so soon after operation. They are a source of irritation."

Dr. Minney.—"One case of epilepsy under my observation, caused by phymosis, was relieved by circumcision. I don't know that

Dr. Halley meant that in every case there were these sclerosed patches, but that when no reflex cause was found it could be attributed to those lesions."

Dr. Felty.—"Four years ago I prepared a paper on epilepsy and communicated with McLain Hamilton in order to get the latest data. Up to that date I had cured three cases by circumcision, and they remained cured for from two to three years. The epilepsy was of the grand mal type. I can hardly believe there could have been a pathological condition of the brain. While these pathological lesions may exist in surgical epilepsy, results of operations, such as circumcision, do not warrant the theory that such lesions exist in the corticle substance."

Dr. Sheldon asked if a bony covering is formed after the operation. "If there is a pathological condition of brain tissue the slight irritation of a phymosis or uterine disease would more likely cause convulsions than if the brain were in a healthy condition."

Dr. Nolder reported a case of a child who had fifteen to twenty spasms a day, and was pronounced hopeless, but the spasms voluntarily ceased and it has had none since.

Dr. Lindsay.—"I regard bromides as our most active agent to control paroxysms, but they should not be given until all hope of curing the case is given up. They injure or deaden the brain, weakening the resistance."

Dr. Harris reported a case of epilepsy in a girl who when she married and became pregnant and while nursing had no attacks, but they returned with menstruation.

Dr. Lindsay.—"We have various reflex disturbances from various causes, but the same cause does not always cause the disturbance."

Dr. Halley.—"There can be no direct connection between irritation of the foreskin and convulsions in the brain. It must be reflex. What do we mean by reflex irritation? It must be some physical change the irritation brings about in the tissues. Injure any portion of the nervous tissue and you get a disturbance of the circulation and anæmic condition of the brain. It brings about the very condition I contended for. You may have anæmic portions without sclerosed patches. In confirmed epileptics these sclerosed patches hrve been found by recent investigators. The sexual system comes closer in relation than any other, and these facts tend along the line of my theory. I do not want the bone to form over the wound. I want to give the brain a chance to expand. It will eventually form in about two years. It is tolerably firm in six months. I would not put the piece back if I could because I do not want it to close. I save the pericranium and turn it over the edge as far as possible, though I pay little attention to this. McEwen claims that when the bone is replaced it is absorbed."

Dr. Lindsay.—"In Dr. Halley's first remarks I supposed he was giving us the pathology of epilepsy. We know that changes of circulation will produce epilepsy, and that in confirmed epileptics we will find sclerosed areas as a result of the changed circulation, rather of recurrent hyperæmia than anæmia. This as in other tissues of the body is a result of hyperæmia, hyperplasia and contraction of the newly-formed tissue. Instead of this being the cause it is a result of epilepsy."

Dr. Halley.—"This explanation is not what I had in mind. Death is really a convulsion, due to anæmia. I referred more in particular to those cases which are due to an injury."

Reported by
W. E. McVey, M.D.

Northeast Kansas Medical Society.

The society met in Kenyon hall, Netawaka, Kansas, December 14, 1892, at 2 P. M. President Dr. P. R. Moore in the chair.

Members present: Drs. Moore, Riggs, Sheldon, Troughton, Farrar, Brown, Fitzgerald, Rafter, Paddock, McVey, Graham and Magee.

Minutes of last meeting read and approved.

The president appointed Drs. Farrar, McVey and Troughton as a committee on program.

Election of officers for the ensuing year resulted as follows:

President.—Dr. Sheldon, of Topeka.

Vice-president.—Dr. Fitzgerald, of Wetmore.

Secretary.—Dr. Magee, of Topeka.

Assistant secretary.—Dr. McVey, of Topeka.

Treasurer.—Dr. Riggs, of Muscotah.

Dr. Farrar, of Atchison, reported a case of "Injury of the Ankle Joint." Foot was entirely cut off. In dressing the wound the astragalus was sawed off. The os calcis was then taken off and subsequently nailed to the astragalus. The flaps were then brought together as well as possible. He has now a good heel to walk on and good ankle movement.

Dr. Moore read his retiring address on "Perityphlitic Abscess." The paper was faultless in every particular and deserves a very careful reading.

In the discussion, Dr. Sheldon said: "It was difficult to improve upon success. The treatment and management of this case were up to the very latest advances in the surgical and therapeutic art. Salines are the best possible drainage of the abdominal cavity, but this case had gone too far for them to give perfect relief without surgical interference. Nature builds up a wall, a barrier to prevent their breaking through into the peritoneal cavity. Perityphlitic troubles tend to become chronic and recur, and between these attacks the vermiform appendix should be removed, which is the source of danger. Some surgeons object to this plan of treatment, yet I think its use is counterbalanced by its danger to the patient if we let it remain. In the abscess there is everything to gain by surgical interference, everything to lose by waiting."

Dr. Fitzgerald, in response to a question from Dr. Paddock as to how far a physician should throw himself liable to the criticism of the patient's friends in demanding operative interference, said: "We should pay no attention to criticism. It is our business to go right on and do our duty. Mark out your course, so tell the patient and his friends, and if this be refused, dismiss yourself from the case."

Dr. Paddock.—"Membranous croup is deceptive. Child may be jolly and playing about and in a few hours choke up and die. We may be able to foresee that when it is so playful that danger is lurking, and if we operate and the child dies, we are blamed. What are we to do? We did the best we knew. How are we to escape censure? How do we explain to the parents that the child would have died anyhow?"

Dr. Troughton.—"Whenever the surgeon knows that he has a surgical case he must so state the case and his line of duty to the friends, and await their decision. He must proceed or get out of the case. By this decisive stand he inspires confidence in those around him. The time is coming when we will use surgical interference in typhoid cases as well as in perityphlitic abscess."

Dr. Riggs and Dr. Fitzgerald were given more time to prepare their papers.

Dr. Riggs reported the results of injecting the glycerole of aristol hypodermically. Said that he had produced compiete local anæsthesia in cats.

Dr. Rafter read an interesting paper on "Varicose Ulcers of the Leg." Favored rest, support and local applications of iodoform and glycerine.

Dr. Sheldon, in discussing the paper, said that varicose ulcers were due to lack of tonicity in the veins. "They are covered with granulations. To relieve these ulcers the lacking tonicity must be supplied by rendering to the vein's support. The surface of the ulcer must be cleansed, for which purpose I use the peroxide of hydrogen, and then applying cosmoline and iodoform and then the elastic stocking. General supporting treatment comes next."

Dr. Troughton.—"I use witch hazel in cleansing the wound, then I apply resorcin to the surface of the ulcer. I also give the witch hazel internally."

Dr. Magee.—"The varicose ulcer appears all along the inner surface of the thigh and leg, and just to the popliteal space on the outer side. This is because the external saphenous vein pierces the popliteal space

and enters the popliteal vein, while the internal saphenous extends to the saphenous opening at Scarpa's triangle and enters the femoral vein. The long-continued standing on the feet with the long column of blood pressing upon the veins tends to favor varicose ulcer."

Dr. Paddock.—"I find these ulcers more often in old men. Study the case and use the agent which I think best adapted to the particular case. Have used calomel, resorcin, aristol, ichthyol, each with good results. After using these I apply mineral earth and bandage."

Dr. Rafter, in closing, said: "I have found great difficulty in keeping the ulcer healed after healing once takes place. Antiseptic treatment and strapping give the best results. I cannot hardly believe that there is a difference between indolent and varicose ulcers. I treat them alike. Ulcers on the outside of legs are due in all probability to syphilis."

Dr. Paddock presented a case of "Corneal Ulcer" to the society, in which there had been perforation with hernia of the iris. On the use of eserine and bandage the case was getting along nicely.

Dr. McVey, of Topeka, now read a paper on "Benign Tumors of the Nose."

In opening the discussion, Dr. Magee said that foreign bodies cause equally as much trouble in the nose as a polypus. Children are apt very frequently to push a bean, shoe button or a wad of chewing gum up into the nose and have to be removed. This can be done with a blunt hook much easier than with the ordinary foreign body forceps. Polypi or hypertrophied turbinates should be removed, as they seriously interfere with the passage of air to the lungs and produce a tendency to mouth-breathing. The histological distinction of benign and malignant tumors is easily discernible with the aid of a microscope. The simple mucous polypus under the microscope gives no well-defined tissue, but a gelatinous mass with here and there a cell, while the sarcoma shows a field entirely filled with the typical round or spindle-shaped sarcoma cell as the case may be.

Dr. Paddock said he had used the blunt hook as recommended by Dr. Magee with success.

Dr. Moore said it was his experience that it was difficult to remove either foreign bodies or tumors from the nose. Was pleased with the form of snare advocated by Dr. McVey.

Dr. McVey, in closing, said that in examining the nose, hypertrophy of the middle turbinate is very often overlooked. That before attempting the removal of a growth from the nares all of the mucous secretions should first be removed so that a full view of the size, shape and location of the tumor can be made out. A snare for the polypi and galvano-cautery for the enlarged turbinates is probably the most successful plan for their removal.

Dr. Sheldon's paper on "Inflammation" was left over until the next meeting, as the hour was late.

An order was drawn on the treasurer for $3, which was paid to defray the expenses of the society.

Society adjourned to meet in Muscotah the second Tuesday in February, 1892, at 9:30 A. M. Respectfully,

R. S. MAGEE, M.D.,
Secretary.

DR. S. M. RIGGS, of Muscotah, has made some interesting experiments in the use of aristol as a local anæsthetic. A hypodermic injection of a solution in glycerine was made into a kitten with the result of complete local anæsthesia. The animal made no resistance to a cutting operation, and was apparently unaware of being injured.

THE last census reports one-fifth of the married in Massachusetts childless. An exchange wants to know whether this is due to arsenical wall paper, the growth of the democratic idea or advances in sterpe culture, or whether manhood has played out in the old boy state. We should say it is the modern Boogeeism that cheats the state of its vital products.

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TOPEKA, KANSAS, JANUARY, 1893.

WE wish you all a merry Christmas and a happy New Year! As we begin with the new year, the fifth volume of the journal, it is meet that we thank you all for your kind words, your willing contributions and your hearty welcome as we have visited you from year to year.

The journal, while young in years, is old in experience. It was neither nurtured in a lap of luxury nor fed with a silver spoon, but like many another pioneer has received many hard knocks and fought many battles with the hungry wolves bent on its destruction.

Four years have come and gone and during that time it has preserved its first friends, has found many new ones, and now, when it makes its New Year calls, it is sure of a hearty welcome by a thousand Kansas physicians.

Time works wonders on this earthly sphere, yet we imagine the man is no better than the boy unless the experience of years as they have rolled by have left their impress on his mind and conscience, and with their accumulated power have marked his thoughts, his acts and his countenance with the stamp maturity. So we trust the journal is no less marked by the experience of its years, no less conscious of its power and no less proud of its labors than the struggling pioneer who has hewn his way to fame and independence through the stone and forest, or has snatched a living, a home, perhaps a fortune, from the drouth and winds of a Kansas prairie.

Each period of its advance in age we wish to mark by some feature of improvement which may add to its merit, increase its power and place it one step higher in the world of science. The growth of the science of medicine, like any other science, is dependent upon the freedom with which one mind gives its thoughts to another and the facility of its transmissisn. A hoard of jewels concealed in the rags of a miser adds nothing to the wealth of the world and brings no comfort to the possessor; neither does a new thought, a scientific experiment or a brilliant discovery, carefully withheld from the public mind, add aught to science nor bring fame to the discoverer.

To journalism must be conceded a share of the honor in the development of scientific thought and investigation; to medical journalism is due the encouragement, the respect and the support of the profession for the aid it has given in the advancement of the science of medicine.

THE next meeting of the Kansas Medical Society will be held in Topeka. We anticipate a large attendance and a profitable program. We trust the members of the society will devote their energies to the program and leave the political wire pulling, which has characterized so many of our previous meetings, to those who are more infatuated by the honors of an office than the advance of medical science.

THE phonograph will demonstrate the alcoholic voice.

Physician and Druggist.

Less than half a century ago the great mass of drugs used by the physician were crude in form, requiring an amount of manipulation impossible to the busy practitioner. The druggist was then a necessity to him. He became his confidential agent in preparing the various concoctions and decoctions he prescribed. While it was necessary that he should know the character and action of drugs, he was then, as he is now, usually wholly ignorant of etiology, physiology, symptomatology and pathology.

To-day with reliable alkaloids and active principles, capable of being carried in a small prescribing case, and a growing faith in mono-pharmacy, the physician can easily carry, and dispense at the bed-side, a large proportion of the remedies he requires. And so the druggist is fast becoming a needless adjunct to the profession, and to-day so many pharmacies are turning out drugs with their uses printed on their labels, many of them good for all diseases, in utter ignorance of all knowledge of diagnosis, well known by intelligent physicians to be the foundation of all success in practice, the druggist is assuming the title and functions of the doctor, and constantly engaging in "counter-prescribing," often leaving, half filled, a prescription for a suffering patient and his waiting agent, while he prescribes and sells to other patrons a box of patent pills, a bottle of proprietory medicine, or, perchance, something of his own compounding, stolen from the prescription of the physician who is honoring him with his confidence and patronage; or it may be that he only keeps the sick man waiting while he sells a keg of paint, a bottle of perfumery, a fly-brush or some other article kept by a neighboring and competing merchant.

So common are the divergencies of the druggist from his legitimate business, so great the delays in procuring through him the necessary medicine for an urgent case, so strong the temptation to substitute for what the prescription always demands — the best and purest drugs — so general the complaint of excessive charges and so easily can he carry a fair supply of the most approved drugs the interests of the physician, as well as those of the patient, must soon compel him to supply his own medicines. Ever ready to sacrifice comfort and even his own health and life in his efforts to save his patient and sustain the dignity of a most humane profession, he cannot afford to trust the druggist who has become his competitor in medicine and a mere tradesman in his own profession, and who delays filling his prescription that he may engage in practice or merchandising. The honest and scientific physician will not be handicapped by a druggist in whose intelligence, singleness of purpose, honesty and promptness he cannot fully rely.

While the scientific druggist may be of great advantage to the physician and his patient, unless he labors with the physician to sustain the dignity of medicine his services should be dispensed with, and the physician should carry his own little case of concentrated agents and dispense them at the home of his patient.

THE Kansas City *Medical Record* devotes considerable space to what the editor facetiously calls the "Physicians' Herd Book," and what is advertised as a Biography of the Eminent Physicians and Surgeons of America. Such a work, prepared with a motive of perpetuating the name and fame of the truly great men of our profession, would meet with a hearty approval, but we feel confident that no physician who appreciates his good name would for a moment consider a proposition to purchase eminence at the rate of $10 a slice.

THE deaths from surgical operation in this city during 1891 were 133 (*N. Y. Med. Journal*). Ten per cent. of these deaths were due to the operations of circumcision, done presumably in those cases by rabbis. The greatest single item was that of deaths from laparotomy; these numbered seventy-six, or fifty-seven per cent.

Hobbies.

Doctors have hobbies and ride them. A hobby is enthusiasm let loose and is like a horse when uncontrolled. The life and vitality and strength and desire are there, but the judgment is set aside, the checks are broken and it is by chance if the goal is reached without accident, if at all. It is possible that a man must be enthusiastic on a subject or in a calling to succeed. When enthusiasm is tempered with judgment, the checks are intact and the force will be directed aright. In no other age has so much hobby riding been done in medicine as in the present one.

Some great light will illuminate the medical heavens for a fortnight, just long enough for the smaller tapers to become ignited, and then, like the last comet, disappear, leaving disappointment for a remembrance, and a flicker or two from the tapers and all is over. But disappointment appears to awaken our curiosity, and we stand with mouths ajar and eyes fixed, and a catchy respiration, and a palpating heart, and vesicular distention, and gasseous inflation of the alimentary tract, balloon-like, ready to ascend whenever some reputed ajax crepitates.

It is the duty of the physician to try everything suggested for the benefit or relief of humanity that is reasonable when he can familiarize himself with the agent, means or plan recommended by whomsoever. But to take every means *ipse dixit* when there is neither reason nor common sense in it, or to practice what he does not know, or, not being familiar with the technique, is not the part of a safe, intelligent practitioner or surgeon. The world is on the *qui vive* for something strange and astounding, and we are of the world and imbibe the same spirit and act the same part. This morbid desire for the curious and unknown is a part of our natures, is inherent and must be controlled by judgment, enlightened by knowledge, knowing what is known. This lack on the part of many of us, in not knowing what we might know, that is knowable, renders us gullible and is the fruitful soil for spurious seed. We do not decry investigation and experiment, for this is essential to progress; but beginning on a false basis, by considering one organ of the body greater than the whole, or relying on the results of imperfect experiments or having a preconceived opinion and acting accordingly, leads to error, and error in the practice of medicine leads to death.

We do not write thus because we are dyspeptic or have borborygmi, or have suffered defeat on the 8th of November, but because we do object to laxness in diagnosis becoming too common, particularly with specialists.

Do not understand me to underrate the value of the specialist. Much of the accurate scientific knowledge in medicine is due to his labor. But there is a tendency to make *the* specialist *the* all; to stop when an error has been found to exist in the favorite organ and to forget that this may be a local expression of a constitutional disturbance, and if the latter is corrected the organ would functionate normally.

If an oculist, the eye is the larger part of the body; if a gynecologist, the uterus and its appendages; if an alienist and neurologist, the mind and nervous system; etc.

How often have the eyes been treated locally and glasses fitted for headache, when a few doses of quinine finally destroyed the malarial element and the headaches ceased, and the glasses were put aside. In failing vision local treatment be applied without avail when an examination of the urine revealed the presence of Bright's disease.

How often have the ovaries been removed, when small cysts only were present, which would probably never do any harm, and afterwards it was found that the trouble was in some other part of the body.

Trephining for epilepsy at a point where some imaginary injury had been received without any benefit, when phymosis was discovered, circumcision was performed and a permanent cure resulted.

The plea, then, is for a more all-around man. The specialist can become so by examining his patients carefully, reading general medical literature, confering and con-

sulting with the general practitioner and surgeon and specialists in all other branches.

When he is in doubt he must call in council, and where he is certain a confirmation of his diagnosis in all grave cases will do no harm, but good to his patient and himself, exit hobby.

How to Choose a Subject for a Paper.

The physician is often at a loss to know what to write about and how to write when his subject is chosen.

What to write about should be determined generally by the diseases prevailing at the time the paper is read, and should be prepared while the writer is treating the class of cases described in the report. Such a paper is timely and will interest every man in the active practice of medicine. The writer will be interested and posted in his subject. If something new is not advanced, the best of the old will refresh the memory and be impressed anew.

Accidents and surgical reports are always in order, as well as reports on obstetrics and gynecology and special work.

The importance of the subject need not be considered, for no affection of the body or mind is too trivial for investigation, and, when written up intelligently, will be both interesting and instructive. The subject should be written up as we think it when we see the case and treat it. Directness and simplicity is the measure of strength of a report. The mind should not dwell upon what others will think of the report, but the facts as they occur and are observed in the case.

In papers, ordinarily, apologies and excuses are not in order. In the former case, if the report is a poor one, disappointment is added to the affliction, and in the latter case it sounds like, "I could have done better, but this is good enough for you." If an explanation is thought to be necessary from the character of the paper, let it be given verbally, and not incorporated in the body of the paper. Reporting just what is seen in a given case, with the plan of treatment and the results obtained, in a clear, concise manner, will not fail to get the attention of a society of medical men and benefit them, and strengthen the physician who makes the effort.

Christ's Hospital of Topeka.

The superintendent and matron, Mrs. McKibben, has secured the services of a number of the physicians in the city who are giving the nurses of that institution a course of instruction on caring for the sick. A training school for the nurses. Mrs. McKibben and the authorities not only deserve praise, but material aid for their self-sacrificing time and labor in their noble work of charity.

These nurses are as well qualified as nurses usually are, but this hospital proposes to have the best nurses and have them keep up with the times by a yearly course of instruction.

What is a Prescription and to Whom Does It Belong?

It is simply a note from a physician to an apothecary, directing what medicine he may deliver to the bearer and what directions he shall append. It should be held in trust by the apothecary for the physician and for his own protection, and should never be refilled without further instruction by the writer.

A HOMEOPATHIC exchange, in summing up its arguments in favor of its pathy, says men of such distinction as Presidents Garfield and Harrison have been its patrons. In our innocence we had supposed the late Surgeon-General Baxter was Garfield's physician, but being out of town when he was shot, Dr. Bliss got the case. If Dr. Bliss is a homeopath we are agreeable. And as President Harrison's wife, her sister and father have all been borne from the white house to the silent tomb during his brief occupancy, homeopathy is welcome to the honors.

Open Tenotomies.

In former years, before the days of asepsis, tenotomies were done subcutaneously. There was a necessity for such surgery because of the danger of sepsis in an open wound. There are but few locations where a tendon can be so divided without injury to other structures. The proper method in dividing tendons is to cut down on them. The surgeon can see just what he is doing; avoid the blood vessels or tie them if cut, and thus prevent hemorrhage and avoid severing important nerves.

The cicatrix resulting from the cut made in the skin amounts to nothing when compared with the safety and success of the operation.

In the open method of tenotomy there is no guess work, but precision.

In the closed method of tenotomies the cutting has to be done in the dark; it is guess work, and as a rule is unsafe and unscientific.

The surgeon of to-day, who has suppuration of a recent wound from tenotomy or amputation, is at fault in all probability in his technique, which means, in English, *cleanliness.*

Castration for Melancholia.

The operation of castrating males for nervous and mental disorders is at last put upon a firm clinical basis. Oophorectomy came from the south and thence diffused its genial and unsexualizing influence over the east and north, but testectomy, if we may coin a word on so great an occasion, comes from the west. It was in 1891 that the Eastern Michigan Asylum published an annual report containing the history of a case in which the operation of castration was done for the relief of a "sickening neuralgia" of the testicles. The patient had not only neuralgia, but melancholia. One of the testicles was removed, and the testicle was found diseased, but not, as we understand the description, cystic or suppurating. The patient improved, but was not cured, and so, later, the second testicle was removed. The medical superintendent, Dr. Burr, now reports that the cure is complete. It is interesting to notice that both testicles had to be removed, just as, in the opposite sex, we are told that both ovaries ought to go in order to get the best results.

Here we have a case of chronic neuralgia and melancholia, in a man of fifty-seven, cured by castration. Neuralgia is very common and so is depression of spirits. There is a fruitful field, therefore, in which ambitious andrologists may work. Shall we not soon begin to get reports of "my second series of one thousand castrations, with hints on technique?"—*N. Y. Medical Record.*

Dr. R. E. McVey, of Topeka, reports two cases of melancholia cured by castration. The first operation was done in 1888 for chronic ataxy and melancholia, resulting from masturbation. Both testicles were removed and the cure was complete.

The second operation was done in 1891 for melancholia and neuralgia of the testicle. In this case only one testicle was removed, and it was found to contain a large cyst and evidences of previous inflammation. A perfect cure resulted.

THE Western Association of Gynecologists and Obstetricians met in Kansas City, December 28 and 29. The meeting was very well attended and the program an exceedingly interesting one. Prominent gynecologists from all over the west were present, and the general interest taken in the meeting speaks well for its future. Kansas physicians were well represented both in attendance and on the program. Dr. Joseph Price, of Philadelphia, was there and favored the society with some very fine clinical operations. Some very excellent papers were read, and the discussions were terse and to the point. Under the excellent chairmanship of Dr. M. B. Ward the business of the meeting was carried out without waste of time, and all discussions were restricted to the subject in hand. We predict for the society a long and prosperous life.

Report of a Case of Veruca Upon the Lips.

BY WM. H. RIGHTER, M.D., TOPEKA, KANSAS.

Tom H. H———, residence Carbondale, Kansas, came to me January 18, 1892, with large warts or veruca papillarus upon the lips. The lower lip was completely covered with these warts and upon the upper lip there were two large ones. His age is fifty-five years; an Englishman by birth. At the age of eighteen these warts began to develop, and at the age of twenty-one they were fully developed, at which time he came to this country. He considered his condition a deformity which was real, and he had not been able to receive any encouragement by those he had consulted, when he came to me through the kindness of my friend Dr. Morgridge of this city. One week from the time I first saw him his warts disappeared, and one week later he had fully recovered the tone of the lips, and they are now as hand some a pair of lips as anyone possesses.

He is as happy as a clam, and he states that his friends cannot recognize him. He feels so elated that he wants to take a trip to England (his old home, which is in East Riden of Yorkshire) to show the English doctors what can be done by Americans.

I report this case because of the rareness of the location of warts. The treatment used in this case was stick caustic, applied once a day for seven days. When treatment was suspended, a thorough cure was established.

Extirpation of the Uterus in a Man.

M. J. Baekel (*Acad. de Medicine*), making a radical cure of hernia in a man, extirpated a tumor consisting of a uterus bicornis, a fallopian tube and a testicle with an epididymitis and a deferent canal. No other example of female genital organs included in the bladder of a man is known. He was otherwise well formed.—*Cin. Med. Journal.*

Picrotoxine in the Night-sweats of Phthisis.

Dr. d'Amore has published his experience with picrotoxine and atropine in the night-sweats of phthisis. He gives the picrotoxine in granules containing 1-160 of a grain each. The author reports forty-five cases thus treated. In fifteen advanced cases he gave without success two pills of atropia containing 1-65 of a grain each daily; in these cases, two to four granules of picrotoxine, continued for several days, relieved the condition very much. In twenty cases, with less pronounced lesions, atropine did well in some and failed in others; but picrotoxine, used for several days, checked the sweating completely. Finally, in ten early cases, the results were equally good from the use of either drug. The writer explains these differences by the cause of the sweating in the several stages of the disorder. In the early stages much of the sweating is due to the action of the secretory nerves, and these are controlled by atropine; later, the sweating is due more to paralysis of the vaso-motors, and as atropine does not act upon these it loses its power, while picrotoxine, which does act upon the vaso-motor system, retains its value in the advanced stage.—*Les Nouveaux Remeaes.*

LITTLE THINGS.

MILK can become a carrier for scarlet fever germs.

THE blood is a highly-organized living tissue.

IT is estimated that nearly one-third of all children die before they reach the age of five years.

SPONTANEOUS dislocations of the crystalline lens are always the corollary of some disease of the eye, not necessarily traumatic.

THE theory that fish is an intellectual or brain food because of the phosphorus it contains is not true according to recent analysis, good beef being equally as rich in phosphates.

But fish is more easily digested than beef and therefore better adopted for brain workers.

OUR secretary of the State Board of Health should receive special commendation for his efforts in the state inspection and quarantine against cholera.

IT is to be hoped that the city council of Topeka will not adopt the proposed dumpage system for getting rid of its garbage, but will use cremation.

VULVITIS and vulvo-vaginitis in young girls is due most frequently to contagion, sleeping with a person suffering from gonorrhœa, or by using the same articles of toilet, and not, as is usually stated, by attempted coitus.

THE city council of Mansfield recently passed an ordinance which prevents any quacks or venders of medicine practicing or selling their wares in that city without first obtaining a permit from the health officer, who is required by the ordinance to be a regular physician. The ordinance requires further that these quacks display a diploma from some respectable medical college before the health officer can give them the necessary certificate entitling them to a license at all. For this license they must pay not less than $25 nor more than $50 per day; and are liable to a fine of $25 nor more than $50 for every violation of the ordinance. In the language of the poet, this is getting there.

The Prevention of Peritonitis.

Mr. Tait's theory of the function of the peritoneum differs essentially from that given in most text-books. He believes that its importance in the human economy is so great that it should be ranked almost next in order to the brain, and does not subscribe to the view commonly expressed that its chief function is to allow free movement of the organs it develops. In his opinion, the strange and invariable plications of this membrane, the exceeding vascularity of its surface, the presence of innumerable stomata, and the profuse nerve supply, derived neither from the motor nor sensory system, all point to some active function, whether it be that of secretion or absorption. All the organs actively engaged in the primary preparation of the systemic nutrients are not only enclosed in the peritoneum, but all the blood gathered from these great organs is collected by a series of minute venous radicles exposed voluminously and immediately under the peritoneal epithelium to any influences which may arise from it.

With regard to the causes of peritonitis, Mr. Tait is equally opposed to the theories commonly held, and forcibly remarks that peritonitis is not a lesion which fits into the germ theory of disease at all. He believes that the influence of the nervous system in the causation of inflammation has been underestimated, and that in peritonitis nerve disturbance contributes more to the death of the patient than microbic invasion. While admitting the existence of a septic peritonitis, he thinks that, save where definable from evidence wholly extrinsic to the condition of the peritoneum, it is an etiological entity which exists only in the mind of the pathological metaphysician.

In the symptomatology of peritonitis the author warns us not to place too much reliance upon records of pulse and temperature, as in this disease they are not only untrustworthy, but may become positively misleading. Alteration of the patient's face and intestinal distension are two signs so constantly present in peritonitis that they always deserve attention. Alteration of the face is deceptive, however, because many fidgety people, and those who bear pain badly, will put on a face indicative of danger when there is none, and the common habit of administering an opiate after an operation to save pain is a source of great danger, for it masks this facial alteration at the time when its aid is most needed — that is, at the onset of the peritonitis. The alteration of the face most to be feared is not one of pain, but of anxiety, accompanied by a tendency to chatter and ask questions; if the patient persistently chatters she is pretty

sure to die. The symptom most to be dreaded is intestinal distension, which occurs at an early period, and, in the author's experience, this condition has been a prominent feature of every fatal case of peritonitis. It is his custom when he sees distension to anticipate peritonitis by the administration of purgatives; if the attempt to purge is successful, the patient recovers; if not, she dies.

The cause of death in peritonitis is, in conformity with Mr. Tait's physiological beliefs, a disturbance of the ebb and flow of the serum stream of the peritoneum and the disturbance of the functions of the liver. It would carry us too far to give in full the ingenious arguments adduced by him in favor of this view. Suffice it to say that he regards bilious vomiting, when fully established after the occurrence of distension, as generally indicative of a fatal issue; and the fourth night as the critical time for all abdominal sections, except those involving the use of the clamp in hysterectomy. If the grave symptoms are all matured on the fourth day after operation, a fatal issue is pretty certain. If they hang over till the sixth or later, the chances of the patient's recovery increase in a geometrical ratio, always excepting cases of hysterectomy. Hence it follows that taking time by the forelock in dealing with peritonitis is everything. The author assails those who talk about treating peritonitis; we must prevent it. His policy is to get control over the vermicular movements of the intestines before the mechanical stasis of the inflammatory process has rendered it impossible. The use of opium by the mouth after operations is vigorously condemned both as modifying or suspending vermicular action, and masking the real condition of the patient. The thirst following abdominal section should not be regarded as an indication for the administration of ice or fluids, but rather for a withdrawal of drinks. Mr. Tait's practice is to keep his patients for as nearly forty-eight hours as may be in absolute starvation, this being modified by age and previous exhaustion. If sickness sets in on the third or fourth day, or at any time after, all food and drink is withheld absolutely for twelve hours or even longer, for nothing can be digested and absorbed by the stomach so long as bile is being poured into it. In his opinion the starvation and withholding of fluid also prevent the mechanical stasis of the circulation in the intestinal coats, which is the initial stage of the fatal process of peritonitis, and this preventive measure may be assisted by stimulating peristalsis. Inasmuch as the mechanical stasis always originates in the transverse colon, stimulant enemata — soap and turpentine are indicated. In the author's practice the nurse is instructed to give an enema, if a passage of flatus per anum does not occur for twenty-four hours after operation, especially if accompanied by the slightest suspicion of distension. If the enema fails, a mild saline purge (generally a seidlitz powder) is administered and repeated every four hours until it acts. The increase of distension should lead us to redouble our efforts to move the bowels, and if successful in this, recovery is usually assured; and even in well-established peritonitis Mr. Tait urges a trial of the purgative treatment, although the chances are against its success.

In conclusion he emphasizes the point that the outcome of a case of peritonitis depends far less on the severity of the symptoms than on the time over which they run; and he has found this peculiarity not only in traumatic peritonitis, but also in other forms and in that known as idiopathic peritonitis. —*Int. Jour. Surg.*

THE state of Kansas has suffered a great loss in the death of Dr. Knapp, for nineteen years superintendent of the State Insane Asylum at Ossawatomie. The doctor, who was one of the ablest specialists and most genial gentlemen in the profession, died at his home in Ottawa, after a brief illness, on the 30th of December.

THE East Kansas Medical Society will meet in Topeka, January 10, 1893.

Pneumonia.

Pneumonia is one of the most fatal of the acute diseases. Hospital statistics show a mortality of from twenty to forty per cent. The season of the year is with us when every physician will meet with cases; and the important question is asked, "Have we anything better to offer in the treatment than we have had in the past?"

The natural history of pneumonia has been studied so carefully that it should be well known by every physician. A self-limited disease for which medicine offers no specific. The expectant plan should be followed in mild cases. Keep the bowels open, regulate the diet, give nutritious food, easily digested, adding to it those well-known digestive ferments that prepare it for absorption. When the patient is restless, a dose of deodorized tincture of opium to secure rest and sleep. In severe cases, when there is pain, counter-irritation. Local depletion over the painful part by cupping is beneficial. Where this does not relieve, a small hypodermic injection of morphia. When the temperature is high, the indication is to lower the temperature and support the heart. Shall we give the well-known antipyretics phenacetin, antipyrine, antifebrin, etc.? We say do not give them. Remember that fever is only a symptom, and is the result of the poison in the blood. Our duty is to eliminate the poison, and this cannot be done by depressing the nervous system and lowering the blood pressure, thus preventing elimination. They add to the amount of poison. In other words, they dam up the poison by preventing excretion. The medication is to favor excretion by keeping the bowels moving freely, the kidneys acting well, the practice of sponging the patient with tepid water, or, as the Germans have long been doing, of using cold packs, or by ice bags is proper. Quinine is of doubtful propriety. It does, in large doses, lower the temperature, but it should be remembered that large doses of quinine suspend digestion, because of its power of destroying the digestive ferments.

We would rely on the use of tepid water, applied by sponging the surface of the body, or cold packs or ice bags, carefully watching the effects. The chief point in the treatment is sustaining the weak heart, and this, it should be remembered, is after all only the result of mal-nutrition.

How shall we treat the cardiac weakness? The testimony of our most reliable advisers gives alcohol as one of our most reliable agents. This should be used early, and for the purpose of tiding the patient over this dangerous period. We have in strychnia a most reliable tonic to the nervous system, and in this a true cardiac tonic. It may be given in doses of 1-20 to 1-50 of a grain, twice or thrice daily. We may with benefit give hypodermatic dose of ether or whisky in failing heart. Ammonia and musk are also valuable. Expectorants are of no value. Nauseants should never be used.

With careful feeding and the wise use of the treatment suggested, we will have given our pneumonic patients the best-known treatment.

Simple Galvanization.

In speaking of the therapeutics of galvanism we begin naturally with the simple passage of the steady current through the tissues of the body by means of sponge electrodes placed on the skin. This is a very extensive theme, and I cannot enter fully upon it now. A very hot dispute has been raised upon the question whether the form of battery which I have named is as good for the treatment of deep-seated nerve lesions as a battery of a few large cells. I am quite unable to decide this question. When muscular contraction is sought, the fifty-cell battery will give about all the contraction that the patient can stand if the poles are rightly placed. I have used this method chiefly for the relief of pain, and in many cases it has given excellent results. On one occasion a lady, ill with influenza, whose headache and pains in the upper portion of the body had yielded to phenacetin, antipyrine, etc., but who still suffered from in-

tolerable aching in the lower limbs, especially about the knees, which was not soothed by hot applications, obtained speedy and permanent relief when I applied a forty-cell current, passing it first from the hip to the ankle and then from one ankle to the other.

In a case of nervous cough, the cough ceased soon after the application of a strong current, one pole being on the back of the neck, the other on the larynx. A dressmaker who had suffered for a week or more from a stiff neck, which compelled her to carry her head on one side, and in addition to its painfulness, greatly interfered with her work, applied to me for relief. I passed a steady current through the affected parts for about fifteen minutes, straightening up and moving the patient's head as the current passed. No other remedy was used. The pain was at once relieved and voluntary motion so restored that no further treatment was necessary.

CATAPHORESIS.

The passage of liquids (and apparently powdered solids) through the skin or other tissues is under certain circumstances greatly favored by the electric current. This phenomenon is called "cataphoresis." My attention was drawn to it recently by an article from the pen of Dr. Hunter McGuire, which was epitomized by me in the editorial columns of the *Maryland Medical Journal*, October 21, 1891. Dr. McGuire reported seven cases in which he had applied tincture of iodine in this way to goitres with considerable benefit; and stated that he intended to use it in hypertrophy of the tonsils. About the same time I made a very interesting observation on a patient. She consulted me for severe neuralia or myalgia of the right shoulder, which she had treated without relief by the application of red pepper on cotton batting. I removed this application and passed a current of some thirty cells through the part. An intense burning sensation resulted, which continued half a day, but was borne patiently by the lady, as the pain had been relieved. In reflecting upon the meaning of this peculiar burning sensation, which was not associated with any redness of the surface, I was forced to the conclusion that the red pepper, left behind by the cotton, had been driven by the current to some depth into the tissues of the skin. I have since frequently applied chloroform to the skin in this way, and it has seemed to me that the relief to pain was greater than by the passage of the simple current. In making the application, the drug to be applied by cataphoresis should be poured on the sponge of the positive electrode, or on a bit of absorbent cotton attached to the positive electrode. This electrode is now placed on the skin over the painful region, while the sponge of the negative electrode, moistened with water, is pressed upon some other part of the surface of the body. Ten or more cells are used. At the point where the positive electrode rests, a burning sensation will soon be felt; and when chloroform is used, this burning will be intensified, and a blister or inflammation of the skin may result if it is applied too long in one place. The whole painful area may be treated in this way with immediate and frequently permanent relief to the pain. I have used this cataphoretic application of chloroform in many cases with marked benefit, although in some instances it failed. I shall refer later, in speaking of the destruction of hairs, to the benefits which I have derived from the application of cocaine to the skin by cataphoresis, complete anæsthesia of the skin being obtainable by its use — so that a needle is not felt when driven into the skin. During the past week, in preparing this paper, I have learned that another had before me made the same observations. The *Annual of the Universal Medical Sciences*, 1892, states that Peterson has employed by cataphoresis "helleborin, strychnine, aconitia, chloroform and cocaine (10 to 20 per cent.) Three or four drops of a one per cent. solution of helleborin on the positive electrode have produced a deeper and more lasting local anæsthesia than cocaine, without constitutional effects. For rheumatic and gouty swellings, solutions of the chloride, benzoate or citrate of lithium should be employed by cataphoresis. Among mer-

curial remedies the imidosuccinate and bichloride are well adapted for such use."

Morton (*Ibid*) asserts that the action of the drug may be limited to the tissues of a part for as long a time as desired, if the blood be first expelled from the part by means of an elastic bandage, or (on the fingers) of a rubber ring. He calls this "anæmic cataphoresis." Fraser and Company prepare medicated and unmedicated plasters for "anæmic cataphoresis."—Dr. Bond in *Maryland Medical Journal.*

Shall Success in Therapeutics be Imperiled by Ethical Consideraitons?

WASHINGTON, D. C., January 13, 1892.

Editor New York Medical Journal:

SIR: I have read and weighed the contents of the letter in your issue of December 19, 1891, on this subject: Shall Success in Therapeutics be Imperiled by Ethical Considerations? That certain points in this letter have made a profound impression upon me is the main reason why I now address you, and respectfully ask that my letter be published in the columns of the journal in vindication of the honorable standing to which all good and true practitioners of medicine aspire.

Dr. Dodge states very clearly a point that is now appealing to every progressive physician—that in these days of advancement in the manufacture of pharmaceutical products we should no longer be confined, as were our forefathers, to prescribing drugs in their crude form, since there are to-day thoroughly-attested remedies in palatable form which our patients can take without repugnance and with benefit.

Now, while the code of ethics is an admirable exponent of the tenets which are acceptable to the great body of practitioners in our country, yet it is at least a question open to discussion whether there are not some points which in our progressive age might be reconsidered and revised. And I would suggest as one subject for discussion the question of the approbation and recommendation of certain proprietary articles which are in almost daily use by very many of our ablest practitioners.

Why should those preparations be condemned simply because their manufacturers are protected under a registered trade-mark? Is it not perfectly legitimate for our medical societies to elect competent committees to be judges of the therapeutical value of tried proprietary preparations? And could not their recommendation also be secured by their indorsement—

1. In didactic and clinical lectures and private instruction given to medical students;
2. In original articles acceptable to the editors of recognized medical journals; and
3. In standard medical works?

I address you particularly on this subject for the reason that the readers of your journal have carefully observed the fearless manner in which you and your able associates have defended the worthy against the unworthy, and given justice where justice was due. We have also seen that your journal has reviewed and commended works by other than medical writers. I have in mind the fact that the very excellent work on the therapeutical application of coca erythroxylon by Angelo Mariani, of Paris, France, the proprietor of the world-renowned Vin Mariani, was favorably reviewed in your journal.

WILLIAM H. HAWKES, M.D.

Acute Gout.

Acute gout comes on unexpectedly in spite of the premonitions, and surprises the patient like a thief in the night. After he has retired, and gone quietly to sleep, he is awakened about midnight by a severe pain. This pain may be in the metatarsophalangeal articulation of the great toe or in any other articulation of the body, from the toe up to the cervical vertebra.

The pain rapidly becomes unbearable, the patient feels as if the affected joint were in a vice; he sighs, moans, throws himself about in bed, the leg, or even the entire body, trembles with pain. Soon after the commencement of the attack, the skin covering the affected joint begins to swell and

redden, and there is fever, with a full bounding pulse, dry skin, intense thirst, concentrated urine, and a great mental excitement. Toward morning there is a remission, but the affected joint remains swollen, shining and very red; the whole leg is slightly swollen by œdema. The next night the scene of the past one is repeated with equal severity; the following day brings another remission, and so on for a week or ten days. Then the swelling, redness and pain gradually disappear, with desquamation of the cuticle, and the parts return to their normal state. I have cured just such cases described above in twenty-four hours by administering tablespoonful doses of Henry's Tri-Iodides every three hours.

A Voice from the Arctic.

Dr. F. A. Cook, who was with Lieutenant

dition, and which resulted in the [illegible] proach to the pole yet attained, writes the following letter to the Antikamnia Chemical Co., which will be of interest as showing how an approved product becomes far-reaching in its work:

NEW YORK CITY, N. Y.,
338 W. 55th St., Nov. 2, 1892.

Gentlemen: The Antikamnia which you sent for use in the North Greenland expedition I used with gratifying results.

For rheumatism, neuralgic pains, as well as the pains which accompany the grippe, it has no equal. Yours respectfully,

F. A. COOK, M.D.,
Surgeon and Ethnologist of the North Greenland Expedition.

WE call the attention of our readers to the advertisement of the Robinson-Pettet Co., Louisville, Ky., which will be found on another page of this issue. This house was established fifty years ago, and enjoys a widespread reputation as manufacturers of high character. We do not hesitate to endorse their preparations as being all they [illegible] m for them.

Cocillana—An Interesting Addition to the Materia Medica.

Respiratory inflammations always form a large proportion of the physician's cases. A Bolivian remedy which gives promise of much therapeutic efficacy is Cocillana, which was introduced a few years ago through the researches of Professor H. H. Rusby, the eminent botanist.

Experiments were made with it by many medical investigators, who found its action very satisfactory in catarrhal inflammations of the respiratory organs, in coryza, hay asthma, bronchitis, acute and chronic, influenza and pneumonia.

It possesses also laxative and purgative qualities, and has been employed successfully as a substitute for ipecac and apomorphia in catarrhal conditions.

Parke, Davis & Co., who introduced the remedy to physicians, will supply reprints of [illegible] es affording information concerning its therapeutic application, and invite the medical profession to test its virtues further by clinical experiment.

They have after much difficulty obtained an ample supply of it, and will be glad to afford any facts desired concerning this or any other of their new remedies for respiratory affections.

Administration of Piperazine.

T. Hewson Bradford, M.D., in the *Medical News*, November 19, 1892, reports his favorable experience with Piperazine. He says:

"The merits of piperazine as a uric acid solvent and its influence upon the uric acid diathesis have attracted considerable attention in the profession. Its easy mode of administration is a great boon to those patients who have been compelled to take for any length of time colchicum, potassium iodide, lithium and sodium carbonates, etc.

"On the 9th of September, 1892, I was consulted by Miss I., seventy years old, for a painful swelling of the right knee, which she attributed to rheumatism, but which, on

account of family peculiarities and her nervous temperament, I diagnosticated as gout.

"Having treated her on several occasions for digestive disturbances, I decided not to give her colchicum, but prescribed phenacetin and salol, and topic applications. These not relieving the trouble, I gave—

℞

Piperazin.....grs. lxiv
Aquæ destil.....f ℥ iv

M. S.: One teaspoonful in half a glass of soda water at 9 and 10 A. M.; 3, 5, 7 and 9 P. M., and on retiring; thus in the course of the day fourteen grains of piperazine.

"The treatment proved very acceptable to the patient, agreed with the digestion, and was followed by marked improvement.

"Careful attention was given to her diet, and there was no gastric disturbance; in every respect the medicine agreed with her, with the exception of the cutaneous trouble which, while annoying, was not attended with any dangerous symptoms."

NOTE.—Piperazine is supplied by the manufacturers in original vials, containing 5 grammes (75 grains); the product is highly deliquescent, and if the full contents of a vial are not dissolved all at one time, the small balance in the vial is difficult to handle subsequently. On this account, therefore, it will be practical and economical to prescribe as follows:

℞

Piperazin.....grs. lxxv
Aquæ destil.....fl ℥ ivss

M. S.: A teaspoonful, etc., as above.—ED.

LISTERINE has no superior as an agreeable as well as efficient antiseptic, so far as efficiency by any means may be practicable for the sick chamber. It consists of the essential ethers and oils of thyme, eucaplytus, baptisia, gaultheria and mentha arvensis in combination with benzo-boracic acid. The vapor evolved by its use in the sick room, by means of spray or saturated cloths hung about, is actively ozonifying and rapidly oxidizing in its effects upon organic matter afloat in the chamber, while at the same time it imparts an agreeable odor to the atmosphere. — *Sanitarian.*

Therapy of Phenacetine.

John V. Shoemaker, A.M., M.D., Philadelphia, writes as follows: "Phenacetine was originally introduced into medical practice as an antipyretic, and subsequently was found to possess analgesic powers. In diseases attended by hyperexia, such as rheumatism, pneumonia, typhoid fever and phthisis pulmonalis, Phenacetine exerts a very happy effect in about half the dose of antipyrine, the ordinary dose being from three to eight grains. The mortality of the typhoid fever of children has been very materially reduced by the employment of Phenacetine. The fall of temperature does not occur until half an hour after the drug has been taken, and the effect continues from four to eight hours. As an antipyretic, Phenacetine is considered by many good authorities as the safest and most efficient member of the aniline group. In epidemic influenza Phenacetine rapidly relieves the muscular pains and favors diaphoresis; the catarrhal symptoms subsequently require other remedies.

"In ordinary colds, one or two five-grain pills of Phenacetine remove all symptoms. The combination of Salol (or Salophen) with Phenacetine is especially useful in influenza and rheumatism.

"The analgesic effects of Phenacetine are very marked in various forms of headache, including migrain and the headaches from eye-strain, having the advantage over antipyrine in not so frequently causing a rash.

"In the neuralgic pains of tabes dorsalis, in herpes zoster and intercostal neuralgia, five-grain doses, given every hour for three or four hours, usually afford complete relief and cause sleep.

"Phenacetine is extremely useful in chronic neuritis, and, according to Kater, is unsurpassed in the treatment of cerebral disorder due to excessive indulgence in alcoholic drinks.

"In whooping cough one-half-grain doses, dissolved in ten drops of glycerine, are readily taken by children and afford prompt relief, permitting sleep and ameliorating the attacks."